Center for Spine Interventions

Date:

History of Present Illness

Name: _____

Date of Birth: _____ Age: _____

Height: _____ Weight: _____

SYMPTOMS (circle all that apply):

Back Pain Neck Pain Arm Pain Leg Pain

1. **The pain has been present for:**
   ____ Days ____weeks ____ months ____ years

   Date of Injury/Onset of Problem: _____
2. **Circle Pain level TODAY:** 0 = none 10 = worst
   0 1 2 3 4 5 6 7 8 9 10
3. **Level of pain on worst day:** (0-10, 10=worst) _____
4. **Is the pain** (circle)**?** Constant **or** comes and goes
5. **Is the pain** (circle all that apply)**?**
   Sharp Dull Stabbing Aching Burning Stiffness
6. **Does the pain go down the arms or legs?** Yes No
   Arms: Right Left Both
   Legs: Right Left Both
7. **Do you have weakness?** Yes No **If yes:**
   Arms: Right Left Both
   Legs: Right Left Both
8. **Do you have numbness?** Yes No **If yes:**
   Arms: Right Left Both
   Legs: Right Left Both
9. **Is the pain worse when** (circle all that apply)**?**
   Sitting standing walking bending lifting
   Twisting lying down morning night
10. **The pain is better when** (circle all that apply)**:**
    Sitting standing walking bending lifting
    Morning night
11. **Does the pain wake you up at night?** Yes No
12. **Do you have fever, chills or sweats?** Yes No
13. **Do you have trouble standing for a long time?** Yes No
    If Yes: _____ minutes
14. **Any difficulty with bowel or bladder?** Yes No
    Describe: _____
15. **Do you drop things with your arms / hands?** Yes No
16. **Are you clumsy with your hands?** Yes No

TREATMENT HISTORY:

Medications: Yes No **If Yes, please list medications**

_____
_____
_____
_____
_____

Have you had Physical Therapy? Yes No

Have you had Chiropractic Therapy? Yes No

Have you had injections for spinal pain? Yes No
Epidural Steroid Injection? Yes No When? _____
Nerve Block? Yes No When? _____
Facet Block? Yes No When? _____

Have you had a Spinal Cord Stimulator? Yes No

When?_____

Have you had Spine Surgery? Yes No **If Yes**:
What type:_____
Names of Surgeon: _____

TESTS you have had (circle all the apply):

CT scan MRI Myelogram Discogram EMG/NCS
DEXA Bone Scan

Is your pain caused by an injury? **YES** **NO**

Work Related? Yes No Date _____

Auto Accident? Yes No Date _____

Other type of injury: _____

Date of injury: _____

Litigation Pending? Yes No

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PREVIOUS EPISODES:

Have you had Neck Pain/Arm Numbness/Arm Weakness BEFORE this episode? Yes No

When? _____

Have you had Back Pain/Leg Numbness/Leg Weakness BEFORE this episode? Yes No

When? _____

PAIN DRAWING

OCCUPATIONAL HISTORY (circle all that apply):

Regular Duty Light Duty Not Working

Disabled Unemployed Retired Homemaker

Not working due to back/neck problems

Not working due to another health problem

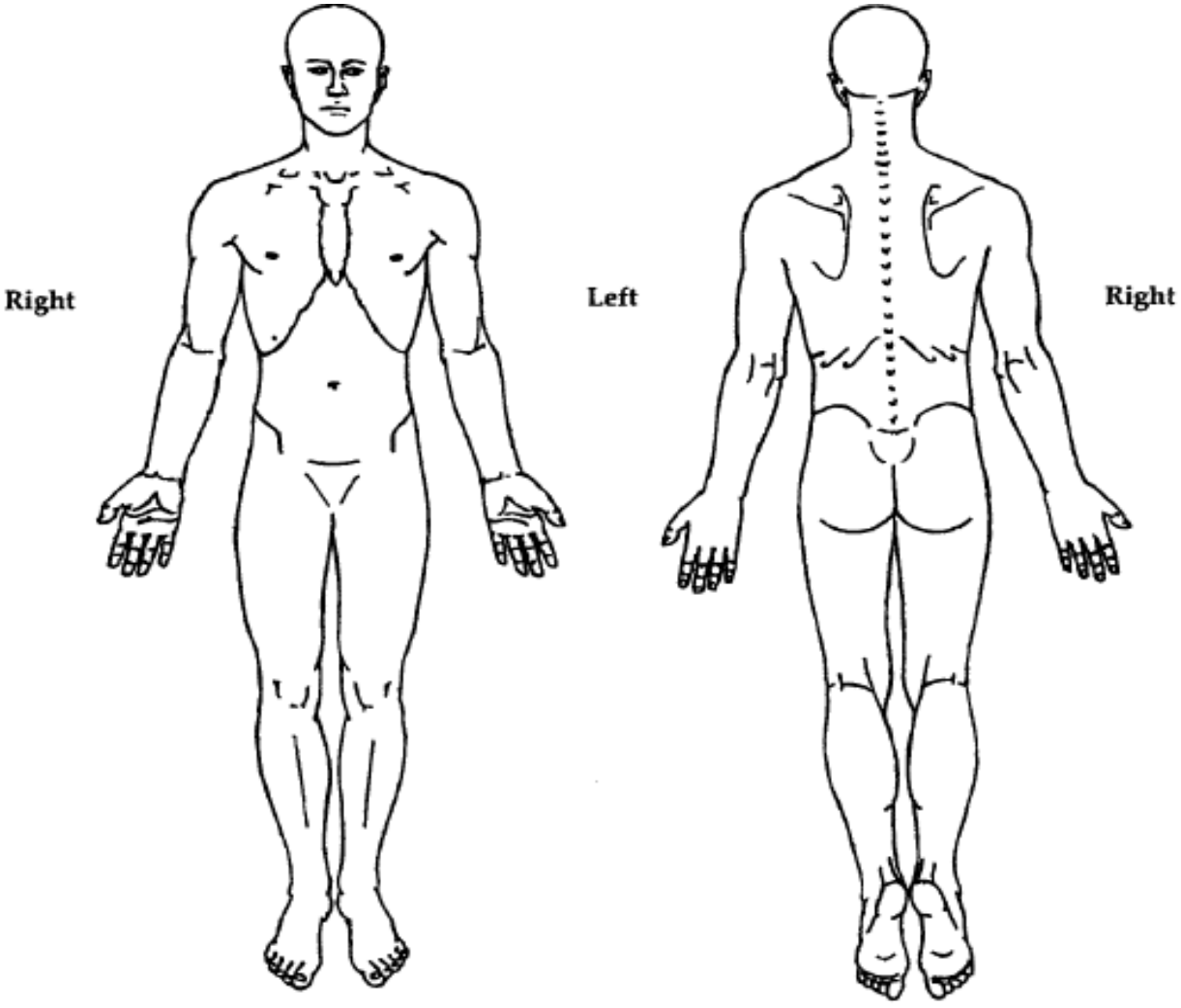
Occupation: _____

Employer: _____

How long have you worked there? _____ Months ___Years

Mark these drawings according to where you hurt (i.e., if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.

Key: Stabbing /// **Burning XXX** **Pins & Needles 000** **Numbness ===** **Aching +++**



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PAST MEDICAL HISTORY:

Please check below if you have, or *have had, any of these medical conditions:*

☐ NO PAST MEDICAL PROBLEMS
☐ Acid reflux
☐ Adverse reaction to anesthesia
Type of Reaction: _____
☐ Alzheimer's or significant memory loss
☐ Anemia
☐ Angina or chest pain
☐ Asthma
☐ Arterial fibrillation or erratic heartbeat
☐ Bladder problems
☐ Bleeding ulcers
☐ Blood clot
☐ Legs ☐ Lungs
☐ Cancer Type: _____
☐ Congestive heart failure
☐ Coronary artery disease
☐ Dental disease
☐ Depression
☐ Diabetes
☐ Emphysema
☐ Epilepsy / Seizures
☐ Fibromyalgia
☐ Gout
☐ Hemophilia/Excessive bleeding
☐ Hepatitis
☐ High blood pressure / Hypertension
☐ High cholesterol
☐ HIV or AIDS
☐ Infections:_____
MRSA? ☐ Yes ☐ No
☐ Kidney disease
☐ Osteoarthritis
☐ Osteoporosis
☐ Pneumonia
☐ Psychiatric disorder
☐ Rheumatoid arthritis
☐ Sickle cell
☐ Sleep apnea
☐ CPAP machine
☐ Stroke (CVA)
☐ Thyroid disease
☐ Other not listed, explain
_____
_____
_____

SURGICAL HISTORY:

Please check below if you have had any of these surgeries:

☐ NO PREVIOUS SURGERY
☐ Abdominal surgery
Type of surgery:_____
☐ Aneurysm
☐ Angioplasty /Stents
☐ Artery bypass of arm or leg
☐ Bone / Joint surgery
Type of surgery:_____
☐ Breast surgery
Type of surgery:_____
☐ Carotid surgery
☐ Cervical spine surgery
☐ Colon surgery
☐ Coronary bypass (CABG)
☐ Gastric bypass surgery
☐ Heart valve replacement
☐ Hysterectomy
☐ Lumbar spine surgery
☐ Pacemaker/Defibrillator
☐ Prostate surgery
☐ Other not listed, explain:
_____
_____

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FAMILY HISTORY:

Please check below if any of your immediate relatives hove had any of the following and list who:

☐ NO FAMILY MEDICAL HISTORY TO REPORT

☐ Adopted
☐ Yes ☐ No

☐ Adverse reaction to anesthesia
Relation: _____

☐ Bleeding disorders
Relation: _____

☐ Blood clots/ Pulmonary embolism
Relation: _____

☐ Cancer
Relation: _____

☐ Depression
Relation: _____

☐ Diabetes
Relation: _____

☐ Heart disease
Relation: _____

☐ Hypertension
Relation: _____

☐ Osteoarthritis
Relation: _____

☐ Rheumatoid Arthritis
Relation: _____

☐ Stroke
Relation: _____

☐ Other not listed, explain
_____
_____
_____

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widow/Widower

Hobbies _____ __

Smoking: ☐ Never smoked ☐ Former smoker ☐ Current smoker How many packs/day? _____

Do you dip or chew tobacco? Y ☐ N ☐ If Yes, how much per day? _____

Do you drink alcoholic beverages? Y ☐ N ☐ If Yes, how many drinks per week? _____

Do you use recreational drugs? Y ☐ N ☐ If Yes, what and how often? _____

REVIEW OF SYSTEMS:

Please check below if you have, or recently experiences, any of these medical conditions:

☐ NO SYMPTOMS TO REPORT

Abdominal pain: Y ☐ N ☐
Anxiety: Y ☐ N ☐
Arm/Leg pain: Y ☐ N ☐
Black, tarry stools: Y ☐ N ☐
Chest pain: Y ☐ N ☐
Dental problems: Y ☐ N ☐
Depression: Y ☐ N ☐
Easy bleeding/bruising: Y ☐ N ☐
Fever/Chills/Night sweats: Y ☐ N ☐
Fatigue: Y ☐ N ☐
Gynecological problems: Y ☐ N ☐
Impotence: Y ☐ N ☐
Incontinence: Y ☐ N ☐
Irregular heart rate: Y ☐ N ☐
Leg swelling: Y ☐ N ☐
Palpitations: Y ☐ N ☐
Psychological problems: Y ☐ N ☐
Seizures: Y ☐ N ☐
Shortness of breath: Y ☐ N ☐
Skin wounds/Rashes: Y ☐ N ☐
Swollen glands: Y ☐ N ☐
Urinating at night: Y ☐ N ☐
Vision Problems: Y ☐ N ☐
Weight gain/loss: Y ☐ N ☐

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LIST ALL KNOWN ALLERGIES TO MEDICATIONS: ☐ **NO MEDICATION ALLERGIES**

1. _____ Reaction type: _____
2. _____ Reaction type: _____
3. _____ Reaction type: _____
4. _____ Reaction type: _____
5. _____ Reaction type: _____

Are you allergic to latex? ☐ Yes ☐ No If so, what is the allergy? _____

Tape allergy? ☐ Yes ☐ No

CURRENT MEDICATIONS:

Include herbal and over-the-counter drugs. List all medications with dosage.

☐ **NOT CURRENTLY TAKING MEDICATION**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____