Washington University in St. Louis Physicians

Welcome!

Washington University School of Medicine
Neurosurgery Spine Center at Washington University
Spine Health History Form

To help us treat you, please fill this form out completely.

Your Name _____ Today's Date ___/___/___

Your Date of Birth ___/___/___

PHYSICIANS

Who referred you to us?

Name of Doctor _____

Fax Number _____

Primary Care Physician

If same as referring, check here: ☐

Name of Doctor _____

Fax Number _____

List any other physicians you would like us to send our notes to:

Name of Doctor _____

Fax Number _____

Name of Doctor _____

Fax Number _____

Name of Doctor _____

Fax Number _____

WHAT PROBLEM ARE WE SEEING YOU FOR TODAY?

_____

_____

_____

Are you: ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

MEDICATION ALLERGIES

Medication _____ Reactions _____

Medication _____ Reactions _____

Medication _____ Reactions _____

Do you have an allergy to latex? ☐ Yes ☐ No ☐ Unknown

MEDICATIONS

Please list all medications you are taking, including over-the-counter medications such as ibuprofen.

Name	Dose	Name	Dose

MEDICAL HISTORY

Have you ever been treated for, or taken medications for, any of the following medical conditions?

☐ Yes ☐ No Abnormal ECG
☐ Yes ☐ No Alcoholism
☐ Yes ☐ No Anemia
☐ Yes ☐ No Aneurysm
☐ Yes ☐ No Anxiety
☐ Yes ☐ No Aortic valve stenosis
☐ Yes ☐ No Asthma
☐ Yes ☐ No Atrial fibrillation
☐ Yes ☐ No Bipolar disorder
☐ Yes ☐ No Bleeding disorder
☐ Yes ☐ No Brain Tumor
☐ Yes ☐ No Cancer
☐ Yes ☐ No Carotid disease
☐ Yes ☐ No Cervical disc disease
☐ Yes ☐ No Cervical stenosis
☐ Yes ☐ No Chest Pain
☐ Yes ☐ No Chronic ear infection
☐ Yes ☐ No Congestive Heart Failure
☐ Yes ☐ No COPD
☐ Yes ☐ No Coronary artery disease
☐ Yes ☐ No Deep vein thrombosis
☐ Yes ☐ No Dementia
☐ Yes ☐ No Depression
☐ Yes ☐ No Dermatitis
☐ Yes ☐ No Diabetes mellitus type 1
☐ Yes ☐ No Diabetes mellitus type 2
☐ Yes ☐ No Diverticulitis
☐ Yes ☐ No Gastric reflux
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No History of blood transfusion
☐ Yes ☐ No HIV/AIDS
☐ Yes ☐ No Hypertension
☐ Yes ☐ No Hyperthyroidism
☐ Yes ☐ No Hypothyroidism
☐ Yes ☐ No Kidney disease
☐ Yes ☐ No Kidney infection
☐ Yes ☐ No Liver disease
☐ Yes ☐ No Lumbar disc disease
☐ Yes ☐ No Lumbar stenosis
☐ Yes ☐ No Marfan syndrome
☐ Yes ☐ No Mitral valve prolapse
☐ Yes ☐ No Mitral valve regurgitation
☐ Yes ☐ No Myocardial infarction
☐ Yes ☐ No Osteoarthritis
☐ Yes ☐ No Osteopenia
☐ Yes ☐ No Osteoporosis
☐ Yes ☐ No Psychosis
☐ Yes ☐ No Pulmonary embolism
☐ Yes ☐ No Rectal bleeding
☐ Yes ☐ No Rheumatoid arthritis
☐ Yes ☐ No Seizures
☐ Yes ☐ No Sickle cell anemia/trait
☐ Yes ☐ No Sinus disease
☐ Yes ☐ No Stroke
☐ Yes ☐ No Substance abuse
☐ Yes ☐ No TIA
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Ulcers (GI)

ACTIVE MEDICAL PROBLEMS

List problems for which you are currently taking medication, or are seeing another physician for, such as high blood pressure, heart problems, etc. Check here if none: ☐

SPINE SURGERY HISTORY

Previous spine surgery. Check here if none: ☐

Type of/Reason For Surgery	Year	Type of/Reason For Surgery	Year

NON-SPINE SURGERIES

Please list any other surgeries you have had, including tonsillectomy, gallbladder removal (cholecystectomy), hysterectomy, etc. Check here if none: ☐

Type of/Reason For Surgery	Year	Type of/Reason For Surgery	Year

FAMILY HISTORY

Relationship	Cancer	Diabetes	Early Death	Heart Disease	Hypertension	Stroke	Other
Mother							
Father							
Sister							
Brother							
Daughter							
Son							
Maternal Grandmother							
Maternal Grandfather							
Paternal Grandmother							
Paternal Grandfather							

Comments: ☐ Adopted ☐ Family History Unknown

PLEASE ANSWER YES OR NO TO EACH OF THE FOLLOWING:

Is this a Workman's Compensation case? ☐ Yes ☐ No

Is this related to an injury or car accident? ☐ Yes ☐ No

Are you currently involved in any litigation or lawsuits? ☐ Yes ☐ No

Have you consulted a lawyer about your injury/problem? ☐ Yes ☐ No

Have you ever seen a spine surgeon before? ☐ Yes ☐ No

For your current problem? ☐ Yes ☐ No

Which surgeons have you seen? _____

PERSONAL/SOCIAL HISTORY

Tobacco Use ☐ Former smoker ☐ Never smoker
☐ Current every day smoker
☐ Current some day smoker
Start date_____ Quit date _____

Smokeless Tobacco Use ☐ Current user ☐ Former user ☐ Never used
Quit date _____

Packs/Day ☐ 1/4 (5 cigarettes) ☐ 1/2 (10 cigarettes)
☐ 1 (20 cigarettes) ☐ 1 1/2 (30 cigarettes)
☐ 2 packs ☐ 3 packs

Years Used ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 10 ☐ 15

Alcohol Use ☐ Yes ☐ No ☐ Defer

Drinks/Week ____ Glasses of wine ____ Cans of beer ____ Shots of liquor

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Work Status ☐ Currently employed: Occupation _____
☐ Not currently employed ☐ Retired
☐ On disability: When disabled _____ Reason for disability _____

REVIEW OF SYSTEMS

Overall, do you feel: ☐ Healthy ☐ As well as can be expected ☐ Terrible

In the past 30 days, have you had any of the following symptoms?

Constitution
☐ Yes ☐ No Appetite change
☐ Yes ☐ No Chills
☐ Yes ☐ No Fatigue
☐ Yes ☐ No Fever
☐ Yes ☐ No Unexpected weight gain

Head, Eyes, Nose, Throat
☐ Yes ☐ No Dental problem
☐ Yes ☐ No Ear pain
☐ Yes ☐ No Hearing loss
☐ Yes ☐ No Trouble swallowing

Breast
☐ Yes ☐ No Breast tenderness

Eyes
☐ Yes ☐ No Eye pain

Respiratory
☐ Yes ☐ No Choking
☐ Yes ☐ No Cough
☐ Yes ☐ No Shortness of breath

Cardiovascular
☐ Yes ☐ No Chest pain
☐ Yes ☐ No Palpitations

Gastrointestinal
☐ Yes ☐ No Abdominal pain
☐ Yes ☐ No Anal bleeding
☐ Yes ☐ No Blood in stool
☐ Yes ☐ No Nausea
☐ Yes ☐ No Vomiting

Endocrine
☐ Yes ☐ No Cold intolerance
☐ Yes ☐ No Heat intolerance

Genitourinary
☐ Yes ☐ No Difficulty urinating
☐ Yes ☐ No Urgency

Muscular
☐ Yes ☐ No Arthralgias/Joint pain
☐ Yes ☐ No Back pain
☐ Yes ☐ No Joint swelling
☐ Yes ☐ No Neck pain
☐ Yes ☐ No Neck stiffness

Skin
☐ Yes ☐ No Rash

Allergy/Immunology
☐ Yes ☐ No Environmental allergies
☐ Yes ☐ No Food allergies
☐ Yes ☐ No Immunocompromised

Neurological
☐ Yes ☐ No Dizziness
☐ Yes ☐ No Headaches
☐ Yes ☐ No Light-headedness
☐ Yes ☐ No Seizures
☐ Yes ☐ No Syncope/Fainting
☐ Yes ☐ No Weakness

Hematologic
☐ Yes ☐ No Bruises/Bleeds easily

Psychiatric
☐ Yes ☐ No Dysphoric mood/depression
☐ Yes ☐ No Nervous/Anxious

DESCRIPTION OF NECK OR BACK PROBLEMS (IF APPLICABLE)

Rate the intensity of your pain by placing an "X" in a box below.

☐ 0 ..... ☐ 1 ..... ☐ 2 ..... ☐ 3 ..... ☐ 4 ..... ☐ 5 ..... ☐ 6 ..... ☐ 7 ..... ☐ 8 ..... ☐ 9 ..... ☐ 10

None | Mild | Moderate | Severe | Very Severe | Worst Pain Imaginable

DESCRIPTION OF NECK OR BACK PROBLEMS

If aplicable, what procedures have you had for the treatment of your current problem? Please check all that apply.

- ☐ Surgery
- ☐ Physical Therapy
- ☐ Relaxation Training
- ☐ Nerve Blocks
- ☐ Tens Unit
- ☐ Biofeedback
- ☐ Steroid Injections
- ☐ Psychological Counseling
- ☐ Chiropractic Treatment
- ☐ Other _____

_____

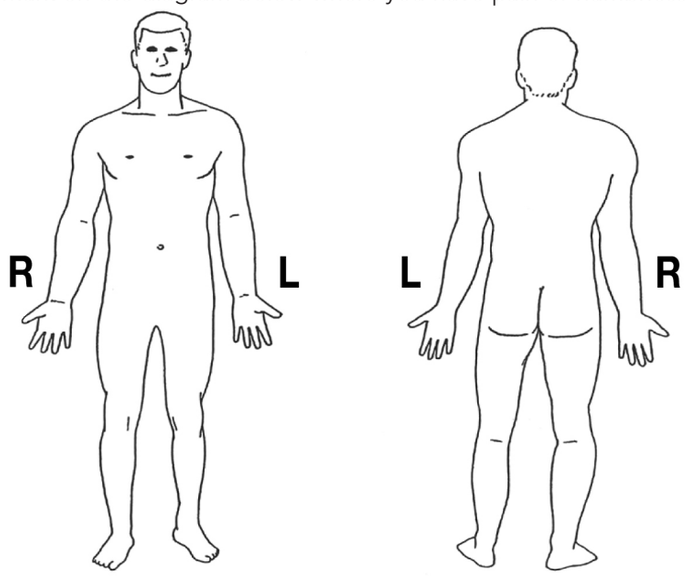
_____

_____

_____

LOCATION OF PAIN OR NUMBNESS

Mark on the diagram below where you have pain or numbness.



PAIN

Check here if you do not have pain: ☐

When did your pain begin? _____

Is the pain: ☐ Improving ☐ Staying the Same ☐ Getting Worse

Is the pain: ☐ Constant ☐ Comes and goes

Where does your pain radiate? ☐ down your arm ☐ down your leg?

Neck and Arms

If your pain is in both your neck and arm(s):

What percentage is in:

Neck ____%

Arm(s) ___%

Back and Legs

If your pain is in both your back and leg(s):

What percentage is in:

Back ____%

Leg(s) ___%

Describe your pain:

☐ Burning ☐ Throbbing ☐ Aching ☐ Stabbing ☐ Tingling ☐ Twisting ☐ Squeezing

☐ Cramping ☐ Cutting ☐ Shooting ☐ Numbing ☐ Vague ☐ Stinging ☐ Indescribable

☐ Pulling ☐ Smarting ☐ Pressure ☐ Coldness ☐ Dull ☐ Other _____

Which side hurts more? ☐ Left ☐ Right

Describe what makes your pain worse _____

Describe what makes your pain better _____

How far can you walk before you need to sit down and rest? _____

How far could you walk 1 year ago, before you needed to sit down and rest? _____

SENSATION PROBLEMS

Where do you have numbness? _____ How long have you had numbness? _____

Describe what makes your numbness worse _____

Describe what makes your numbness better _____

Have you experienced electrical jolts down your spine, arms or legs? ☐ Yes ☐ No Where? _____

BOWEL/BLADDER PROBLEMS

Describe any bladder problems _____ Describe any bowel problems _____

_____ _____

How long have you had bladder problems? _____ How long have you had bowel problems? _____

BALANCE

Describe any problems with your balance _____

_____

WEAKNESS

Describe any weakness in your arms or legs (include examples) _____

_____

How long have you had this weakness? _____

Have you noticed any change in your dexterity, such as picking up change or buttoning your shirt? ☐ Yes ☐ No

If so, please describe _____

Describe what makes your weakness worse _____

Describe what makes your weakness better _____

INJURY

If this visit is due to an injury, please describe **in detail** when and how it occurred. Be specific.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Physician Signature _____ Today's Date ____/____/____