Spine Health History Form

Welcome to the Neurosurgery Spine Center at Washington University. To help us treat you, please fill this form out completely.

Your Name:_____ **Today's Date:** _____

Your date of birth: _____ **Your age:** _____

Who referred you to us: _____

Who is your primary care physician: _____
(if same as referring, check here: ☐):

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

What problem are we seeing you for today:
_____
_____
_____
_____

Are you (please circle one): right-handed, left-handed, ambidextrous

Allergies to medications: (check here if you do NOT have any known allergies to medications: ☐)
_____
_____
_____

	YES	NO	UKNOWN
Do you have an allergy to latex?.....	☐	☐	☐

Medications: (please list all medications you are taking, including over-the-counter medications such as ibuprofen)

Name	Dose	Name	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past medical history

Active medical problems. These are problems for which you are currently taking medication or are seeing another physician, such as high blood pressure, heart problems, etc...): **(check here if none: ☐)**

_____
_____
_____

Past medical problems. Have you ever been treated for, or taken medications for, any of the following medical conditions:

YES	NO	
☐	☐	Diabetes (high blood sugars)
☐	☐	Hypertension (high blood pressure)
☐	☐	Heart disease
☐	☐	Heart attack
☐	☐	Congestive heart failure
☐	☐	Asthma
☐	☐	Tuberculosis
☐	☐	Glaucoma
☐	☐	Osteopenia (mild weakening of the bones)
☐	☐	Osteoporosis
☐	☐	Stroke/TIA
☐	☐	Seizures
☐	☐	HIV/AIDS
☐	☐	Hepatitis
☐	☐	Bleeding disorder
☐	☐	Depression

Past surgical history:

Previous spine surgery (with dates): (check here if none: ☐)

_____
_____
_____
_____

Non-spine surgeries (with dates): Please list any other surgeries you have had, including tonsillectomy, gallbladder removal (cholecystectomy), hysterectomy, etc...**(check here if none: ☐)**

_____
_____
_____
_____

Family history: (please indication any major medical problems in your family members)

YES	NO	
☐	☐	Diabetes
☐	☐	Stroke
☐	☐	Hypertension
☐	☐	Heart disease/heart attack
☐	☐	Cancer

Other family medical history:

_____
_____
_____
_____

Please answer yes or no to each of the following:

	YES	NO
Is this a workman's compensation case?.....	☐	☐
Is this related to an injury or car accident?.....	☐	☐
Are you currently involved in any litigation or lawsuits?	☐	☐
Have you consulted a lawyer about your injury/problem?	☐	☐
Have you ever seen a spine surgeon before?.....	☐	☐
For your current problem?.....	☐	☐

Which surgeons have you seen?_____

Personal/social history:

Tobacco use: ☐ Never

☐ Previously used
Year quit: _____
packs/day when using: _____

☐ Recently quit
#packs/day when using: _____

☐ Current:
Number of years using: _____
#packs/day: _____
Have you ever quit before? _____

☐ Other nicotine use (chewing tobacco, cigar, pipe)

Alcohol use:
☐ Never/rarely
☐ Occasionally/socially
☐ Moderate (2 drinks/day on average)
☐ Heavy (more than 2 drinks/day on average)

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?:

YES	NO	
☐	☐	**Tiredness/fatigue**
☐	☐	**Fevers**
☐	☐	**Chills**
☐	☐	**Sweat heavily at night (night sweats)**
☐	☐	**Recent weight loss (unintentional)**
☐	☐	**Headache**
☐	☐	**Chest pain**
☐	☐	**Palpitations (heart racing)**
☐	☐	**Shortness of breath**
☐	☐	**Difficulty breathing during exertion**
☐	☐	**Cough**
☐	☐	**Difficulty swallowing**
☐	☐	**Heartburn (acid reflux)**
☐	☐	**Nausea**
☐	☐	**Vomiting**
☐	☐	**Incontinence of bowels (unable to restrain bowels)**
☐	☐	**Incontinence of bladder (unable to restrain urine)**
☐	☐	**Easy bleeding**
☐	☐	**Easy bruising**
☐	☐	**Diffuse joint pains (arthralgias)**
☐	☐	**Muscle aches**
☐	☐	**Anxiety**
☐	☐	**Depression**

Description of Neck or Back Problems (if applicable)

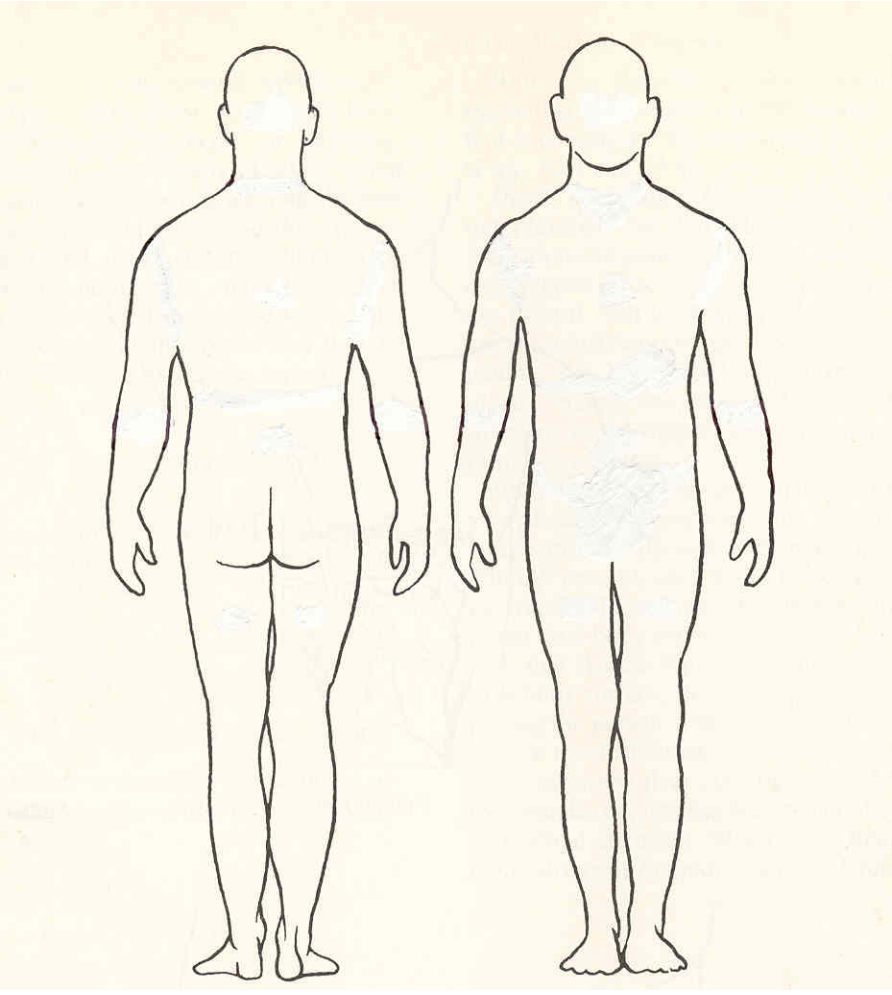
Rate the intensity of your pain by placing an "X" on the line below.

No Pain Worst pain imaginable
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

What procedures have you had for the treatment of your current problem? Please check all that apply.

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

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 ☐ Does it come and go
- Where does your pain radiate down your arm or leg?
- If your pain is in your neck and arm(s), what percentage is in your neck and what percentage is in your arm(s)? _____%Neck _____%Arm(s)
- If your pain is in your back and leg(s), what percentage is in your back and what percentage is in your leg(s)? _____%Back _____%Leg(s)
- Describe your pain (aching, stabbing, burning,etc.)
- 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? Where?

BOWEL/BLADDER PROBLEMS

- Describe any bladder problems:
- How long have your had bladder problems?
- Describe any bowel 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? 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).