ORTHOPAEDIC SPECIALISTS OF AUSTIN

## SPINE HISTORY

| | | | |
|---|---|---|---|
| PATIENT NAME: | | DATE: | |
| Patient's Date of Birth: | | | |
| Referring Doctor: | | Phone: | |
| Address: | | | |
| Family Doctor: | | Phone: | |
| Address: | | | |
| ☐ Right-Handed ☐ Left-Handed | Weight: | Height: | Age: |

## HISTORY OF PRESENT ILLNESS

Reason for your visit:

Is this the result of an injury? Yes / No (circle one)

If Yes, did the injury occur while at work? Yes / No (circle one)

Date of injury: Location of injury:

How did injury occur?

Where is the majority of your pain?

| | | |
|---|---|---|
| ☐ Leg Pain RIGHT / LEFT / BOTH (circle) | ☐ Back pain | ☐ Both |
| ☐ Arm Pain RIGHT / LEFT / BOTH (circle) | ☐ Back pain | ☐ Both |

## EVALUATION OF PAIN / DISCOMFORT

When did the problem start?

Duration of pain? ☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant

Onset of pain? ☐ Acute ☐ Chronic ☐ Gradual worsening

Description of pain? ☐ Sharp ☐ Ache ☐ Burn ☐ Numb ☐ Cramp ☐ Stabbing

**Pain Scale** MILD MODERATE SEVERE (Circle one number)

NO PAIN 1 2 3 4 5 6 7 8 9 10

What makes it feel better? ☐ Sitting ☐ Standing ☐ Walking
☐ Bending forward ☐ Bending back ☐ Coughing/sneezing

What makes it feel worse? ☐ Sitting ☐ Standing ☐ Walking
☐ Bending forward ☐ Bending back ☐ Coughing/sneezing

Is the pain activity-related? Yes / No

Associated signs ☐ Weakness ☐ Numbness ☐ Loss of bladder ☐ Gait problem ☐ Headache

Prior diagnosis ☐ Fracture ☐ Osteoporosis ☐ Arthritis
☐ Herniated disc ☐ Degenerated disc ☐ Stenosis

## PREVIOUS TREATMENT FOR THIS PROBLEM

Diagnostic Testing (circle all that apply) X-Rays CT MRI EMG Other:_____

Medications taken (past or current) for this problem:

| | | |
|---|---|---|
| Anti-Inflammatories | ☐ Helpful ☐ Not Helpful | Other treatment(s) for this injury: |
| Injections | ☐ Helpful ☐ Not Helpful | |
| Physical Therapy | ☐ Helpful ☐ Not Helpful | |
| Chiropractics | ☐ Helpful ☐ Not Helpful | |
| Acupuncture | ☐ Helpful ☐ Not Helpful | |

Have you seen other doctors for this condition? Yes / No If Yes, who?_____

Is this condition being covered by Worker's Compensation? Yes / No

Is there a lawsuit or litigation pending in regard to this condition? Yes / No

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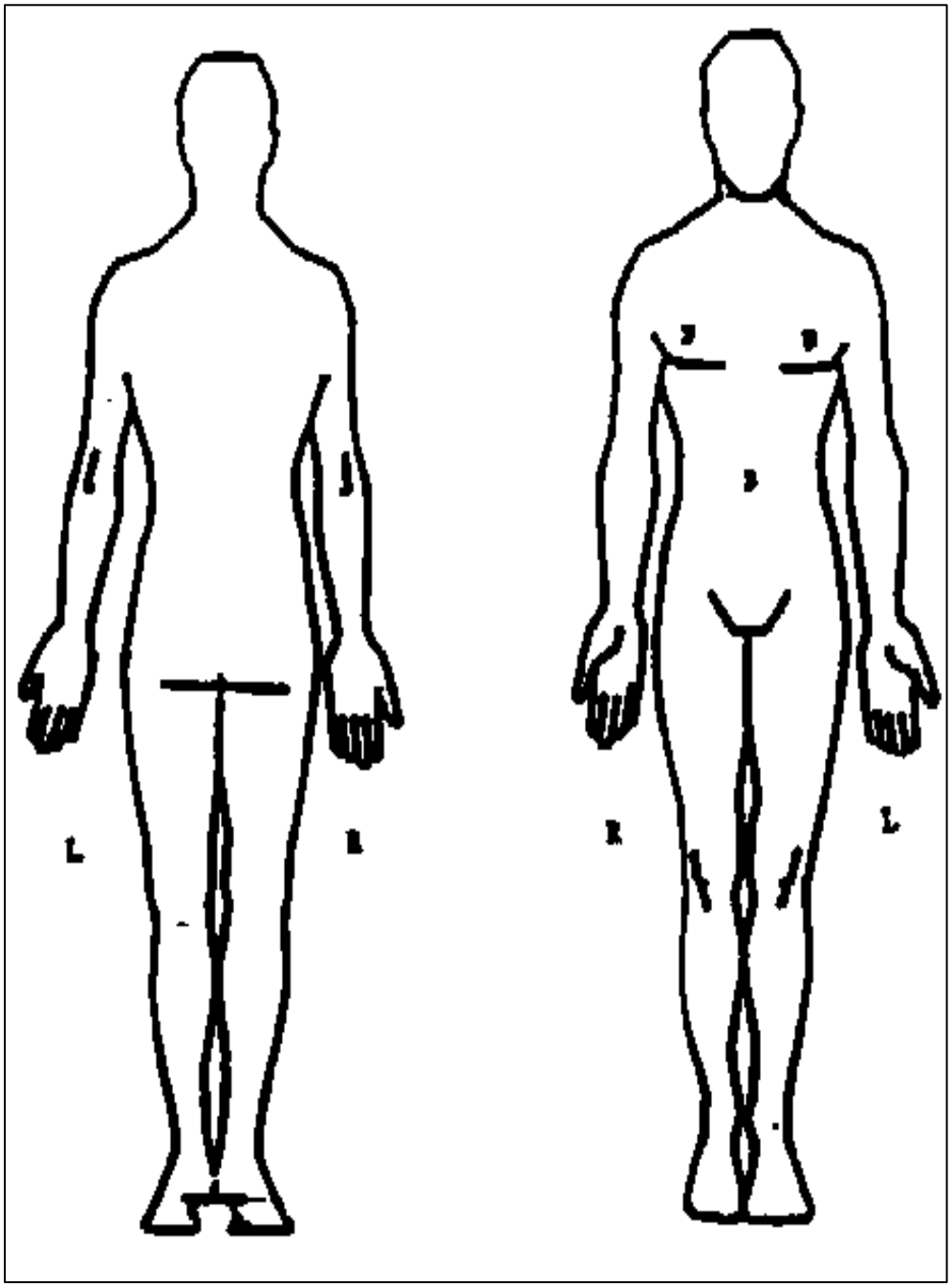
Mark the drawing below using the symbols that best describe your pain

**Numbness** = = = = = = = = = = **Ache** ^ ^ ^ ^ ^ ^ ^ ^ ^ ^ ^ ^ ^ ^ ^ ^ **Pins and needles** o o o o o o o o

**Stabbing** / / / / / / / / / / / / / / / / / / / / **Burning** x x x x x x x x x x x x x x **Cramping** + + + + + + + + + + + + +



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| PAST MEDICAL HISTORY (check all that apply) | | |
|---|---|---|
| ☐ Diabetes | ☐ Bleeding tendencies | ☐ HIV/AIDS |
| ☐ High blood pressure | ☐ Blood clots | ☐ Hepatitis |
| ☐ Stroke | ☐ Cancer | ☐ Vascular Disease |
| ☐ Heart disease | ☐ Ulcers | ☐ Anesthesia difficulties |

| PAST SURGICAL HISTORY | | | |
|---|---|---|---|
| Describe: | Year: | Describe: | Year: |
| Describe: | Year: | Describe: | Year: |
| Describe: | Year: | Describe: | Year: |

| MEDICATIONS (please list all prescription and non-prescription medications that you are currently taking) | | | | | |
|---|---|---|---|---|---|
| Medication Name | Dose | How often | Medication Name | Dose | How often |
| | | | | | |
| | | | | | |
| | | | | | |

| ALLERGIES (medications, metals, etc.) |
|---|
| List: |

| FAMILY HISTORY (check all that apply) | | |
|---|---|---|
| ☐ Cancer | ☐ Diabetes | ☐ Musculoskeletal disease |
| ☐ Heart disease | ☐ Malignant hyperthermia | ☐ Anesthesia difficulties |
| ☐ Stroke | ☐ Bleeding disorder | |

| SOCIAL HISTORY (check all that apply) | | | |
|---|---|---|---|
| ☐ Married | ☐ Single | ☐ Divorced | ☐ Widowed |
| ☐ Live alone | ☐ Live with family | ☐ Live with friends | ☐ Live in nursing home |
| Do you smoke: Yes / No | How many packs/day? | | How many years? |
| Alcohol consumption: ☐ None | ☐ Minimal | ☐ Moderate | ☐ Heavy |
| Occupation: | | Last day worked: | |

| REVIEW OF SYSTEMS (check all that apply) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Skin | ☐ | Rash | Throat | ☐ | Sore throat | GI | ☐ Weight loss or gain |
| | ☐ | Psoriasis | | ☐ | Hoarseness | | ☐ Abdominal pain |
| Heme | ☐ | Bleeding tendencies | | ☐ | Snoring | | ☐ Liver disease |
| | ☐ | Bruise easily | CV | ☐ | Heart attack | | ☐ Constipation |
| Eyes | ☐ | Visual loss | | ☐ | Irregular heartbeat | GU | ☐ Kidney stones |
| | ☐ | Double vision | | ☐ | Chest pain or pressure | | ☐ Bladder infections |
| Ears | ☐ | Decreased hearing | Lungs | ☐ | Shortness of breath | | ☐ Blood in urine |
| | ☐ | Ringing in ears | | ☐ | Asthma | Endo | ☐ Diabetes |
| Nose | ☐ | Sinus probs | | ☐ | Bronchitis | | ☐ Thyroid |
| | ☐ | Breathing probs | | ☐ | Pulmonary emboli / DVT | Skeletal | ☐ Osteoporosis |
| Psych | ☐ | Depression | Neuro | ☐ | Seizures | | ☐ Rheumatoid Arthritis |
| | ☐ | Hallucinations | | ☐ | Headaches | | ☐ Gout |