University of New Mexico
Department of Orthopaedics
Division of Spine Surgery

Name: _____ Date of birth: _____ Today's date: _____

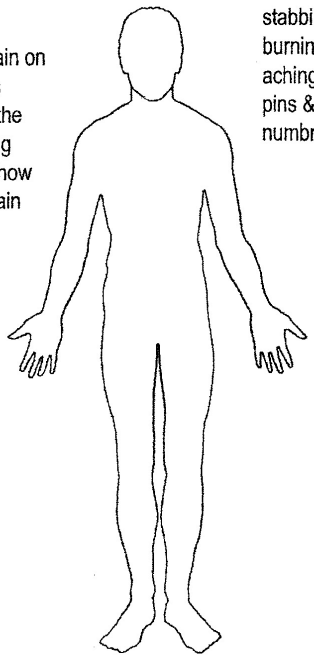
Tell us about your symptoms?

• What are your symptoms?_____
_____
• Is this pain mostly in the back, neck or elsewhere?
_____
• How long ago did these symptoms begin? _____
• How did they begin? _____
• Is the pain constant, or does it come and go?_____
_____
• How do these symptoms limit you? _____
_____
• What things make the pain better? (rest, ice, heat, pills?)_____
• What makes the pain worse? _____
_____
• Do you have pain that radiates into the arm or leg?
( ) no ( ) yes, describe _____
• Have you lost control of your bowel/bladder functions?
( ) no ( ) yes, describe _____
• Do you have any weakness or numbness/tingling in an arm or leg? ( ) no ( ) yes, describe _____
• How long can you . . .
Sit _____ stand _____ walk _____
• **Is your pain the result of a**
( ) fall ( ) auto accident ( ) injury on the job
( ) other _____
• Have you ever had back/neck problems before this injury? ( ) no ( ) yes, describe _____
• Employer at the time of injury _____
• Does your job require lifting, standing, sitting?
_____
• Is there a lawsuit pending on this problem?
( ) yes ( ) no
• **Who treated you first for this problem?**
Dr. _____ City: _____
• What treatments did you have then? _____
_____
• What tests have you had?
( ) CT scan ( ) MRI ( ) X-ray ( ) EMG
Other _____
• Did you have any injections for your problem?
( ) no ( ) yes, describe _____
• Did these injections help?
( ) no ( ) yes, describe _____
• Did you have previous back or neck surgery? _____
_____
• Have you had physical therapy for this problem?
( ) no ( ) yes, describe _____
• Did this therapy help?
( ) no ( ) yes, describe _____
• Do you do any special exercises for your back or neck?
_____
• What do you hope to accomplish today? _____
_____
• What other concerns do you have?
_____

Front

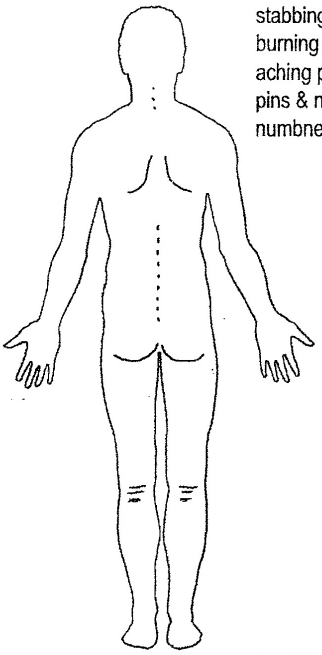
Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.

stabbing pain	/////
burning pain	ooo
aching pain	xxx
pins & needles	vvv
numbness	===



Back

stabbing pain	/////
burning pain	ooo
aching pain	xxx
pins & needles	vvv
numbness	===



Circle your pain level on a scale of 1 to 10, with 10 being unbearable, or worst imaginable, pain.

1 2 3 4 5 6 7 8 9 10
no pain extreme pain

Health History Form

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

List all **past medical problems**:

_____

_____

_____

_____

List all **current medical problems**:

_____

_____

_____

_____

Are you currently pregnant or do you think you are pregnant? _____

List all current **medications**: _____ _____

(including over-the-counter _____ _____

and herbal/supplements) _____ _____

What medications have you tried in the past: _____

List all **DRUG ALLERGIES** including adverse reactions.

Review of Systems:

Are you currently having or have you had problems with your:

	Circle		**Describe all yes responses**
Eyes	**No**	**Yes**	_____
Ears, Nose, Throat	**No**	**Yes**	_____
Lungs, Breathing	**No**	**Yes**	_____
Digestion/Ulcers	**No**	**Yes**	_____
Bowel movement	**No**	**Yes**	_____
Bladder problems	**No**	**Yes**	_____
Diabetes	**No**	**Yes**	_____
Heart problems/Chest Pain (including rheumatic fever)	**No**	**Yes**	_____
High blood pressure	**No**	**Yes**	_____
High cholesterol	**No**	**Yes**	_____
Bleeding problems/Blood clots	**No**	**Yes**	_____
Balance problems	**No**	**Yes**	_____
Numbness/tingling	**No**	**Yes**	_____
Blackout/fainting	**No**	**Yes**	_____
Psychological problems/Depression	**No**	**Yes**	_____
AIDS/Hepatitis	**No**	**Yes**	_____
Cancer	**No**	**Yes**	_____
Arthritis/rheumatoid	**No**	**Yes**	_____
Weight loss/weight gain	**No**	**Yes**	_____
Epilepsy	**No**	**Yes**	_____
Migraines or headaches	**No**	**Yes**	_____
Skin, e.g., rashes, lesions, moles	**No**	**Yes**	_____

Past Surgical History

Have you ever had any problems with anesthesia? **No** **Yes** Explain_____

Surgery	**Year**	**Complications**

Family History

Do any of your grandparents, parents, siblings, or children have any of the following diseases? Please explain.

Diabetes	**No**	**Yes**	_____
High blood pressure	**No**	**Yes**	_____
Heart attack	**No**	**Yes**	_____
Cancer	**No**	**Yes**	_____
Arthritis	**No**	**Yes**	_____
Rheumatoid arthritis	**No**	**Yes**	_____
Back or neck problems	**No**	**Yes**	_____
AIDS/HIV	**No**	**Yes**	_____
Bleeding disorders	**No**	**Yes**	_____
Epilepsy	**No**	**Yes**	_____
Hepatitis	**No**	**Yes**	_____
Migraines/headaches	**No**	**Yes**	_____
Psychiatric problems	**No**	**Yes**	_____
Stomach	**No**	**Yes**	_____
Thyroid problems	**No**	**Yes**	_____

Social History

❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Widowed

Do you live alone? No Yes

❒ Employed (occupation _____) ❒ Student ❒ Retired

❒ Not working because of back or neck problem Date last worked _____

Children? No Yes #____

Exercise? ❒ Never ❒ Rarely ❒ Weekly ❒ Daily

What type of exercise?_____

Smoking? No Yes _____ Packs per day for _____ years.

Quit smoking? No Yes When? _____

Previously smoked _____ packs per day for _____ years.

Chew tobacco? No Yes How much? _____

Drink alcohol? No Yes How much and how often? _____

History of substance abuse? No Yes What? _____

Patient Signature _____ **Date** _____

Reviewed by _____ **Date** _____

MD Signature_____ **Date** _____