PIEDMONT Spine Specialists

For office use only:
Pulse:_________
Temp:_________
RR: ___________

MEDICAL QUESTIONNAIRE

Name (print): ________________________________ Appointment Date: _______________ Chart #:______________

Age: ______ F M Height: _____|_____ Weight: ________ Dominant Hand R L Did you bring x-rays? Y N

Who requested that you visit the office? (name) ______________________________ MD/DO PA/NP Attorney None

What is the main reason for the visit? Pain Numbness Weakness Swelling Stiffness
Other___________________

What body part is involved? Please mark below:

Neck	and **radiates** to	R arm L arm Neither	Shoulder R L	Arm R L	Elbow R L	Wrist R L	Hand R L	Finger 12345 R L
Back	and **radiates** to	R leg L leg Neither	Pelvis R L	Hip R L	Knee R L	Ankle R L	Foot R L	Toe 12345 R L

How long ago did it start? ______ Days _______Weeks ______Months ______Years. Had a problem like this before? Y N

How did your problem start? Check only one category please:

No Injury – Onset was Gradual Sudden. Why do you think it started?
Injury Accident Sport. Date_______ Where and how did it happen?
Injury at Work Date_______ From Lift Twist Fall Bend Pull Reach.
Work related, but NO injury Date_______ How did your job cause the problem?
Auto Accident Date_______ How was your vehicle hit? Were you driving? Y N Seat belt on? Y N Air Bag deployed? Y N Lose consciousness? Y N
Answers and Comments:

Please circle how **severe** your pain is (10 is the worst possible pain) 0 1 2 3 4 5 6 7 8 9 10

What is the **quality** of the pain? Sharp Dull Stabbing Burning Aching Throbbing

Does your pain wake you from sleep? Y N The pain is Constant Comes and Goes (Intermittent)

Do you have? Numbness Tingling Weakness Lost control of Bowel or Bladder Swelling Bruising

Since my problem started is it? Getting Better Getting Worse Unchanged

What makes your symptoms **worse**? Lifting Twisting Bending Squatting Kneeling Stairs
Standing Walking Sitting Exercise Lying in Bed Coughing Sneezing Other_____________________

What makes your symptoms **better**? Rest Elevation Ice Heat Other_________________________________

Have you ever had a similar problem in the past? Y N If yes, explain_______________________________

What medications have you taken for this problem? ____

Have you had any of these tests? X-rays MRI CAT Scan Bone Scan EMG/NCV (Nerve Test)

Were you seen in the ER? Y N If yes, Where________________________________ Date________________

Have you had any of these treatments? Injection Epidural Therapy Brace Cane/Crutch Other_______________

Have you had surgery for a problem in the same area? Y N If yes, please list procedure(s), surgeon, date

____

What is your current work status? Regular Light Duty (How Long? ______) Not working due to this problem Disabled
Retired Student When is the last day you worked your regular job? ______________________

Are you currently receiving or plan to apply for Disability Workers' Comp Unemployment

Anything else you want to tell us about your problem? ____

____

Name (print) ______________________________ Appointment date: ______________ Chart#: __________

REVIEW OF SYMPTOMS:

Circle any condition below that you have, or check None to the right of the section

	Conditions	None	Describe
MS	Arthritis, Gout, Back Pain, Osteoporosis, Fracture Which bone?, Neck Pain		
GI	Heartburn, Ulcers, Nausea, Vomiting, Hepatitis, Liver disease, Blood in stool		
ENDO	Thyroid disease, Frequent thirst, Frequent urination, Always hot or cold		
CONST	Weight loss, Frequent fever, Loss of appetite		
EYE	Blurred vision, Double vision, Vision loss		
ENT	Hearing loss, Hoarseness, Trouble swallowing		
C-VASC	Chest pain, Palpitations, Passing out		
RESP	Chronic cough, Shortness of breath, Wheezing		
GU	Painful urination, Blood in urine, Kidney problems		
SKIN	Frequent rashes, Lumps, Skin ulcers, Psoriasis		
NEURO	Headaches, Dizziness, Seizures		
PSYCH	Drug/Alcohol problem, Depression, Sleep disorder		
HEME	Easy bleeding/bruising, Anemia, HIV/AIDS, Hemophilia		
ANY OTHER CONDITIONS NOT MENTIONED?			

ALLERGY: Do you have any **allergies** to medications? **Y N** If **YES** list medication **and** describe the allergic reaction below

Medication	→	Reaction	Medication	→	Reaction
	→			→	
	→			→	

PAST MEDICAL HISTORY

What medications do you take for this or any other medical problems? Include over-the-counter medicines, dietary or herbal supplements or any others. Please list below with the dosage.

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

Are you a diabetic? Y N TREATMENT: Insulin Oral Meds Diet None

HAVE YOU EVER HAD ANY OF THE CONDITIONS LISTED BELOW? PLEASE CIRCLE.

I do not have any of the conditions listed below.

Ankle swelling	Aspirin Sensitivity	Asthma	Bleeding Ulcers	Cancer (location)
COPD	Heart Disease/Failure	Heart Attack (year)	Hepatitis	High Blood Pressure
Kidney Failure	Liver Disease	Stroke	Sulfa allergy	Others Not Listed?

Stomachache taking anti-inflammatories /NSAIDS Which ones? ______________

Blood clots? Y N When? Are you taking or have you ever taken blood thinners? Y N If **YES**, which one? __________

PAST SURGICAL HISTORY:

What operations have you had? When? None______________

____

Have you ever had a reaction to anesthesia or local anesthetics? Y N______________

PAST HOSPITALIZATIONS AND DATES (Not for surgery) None ______________

____

FAMILY HISTORY: Have any direct relatives had any of the following disorders? If so, which relative?

Hemophilia_____ High Blood Pressure______ Heart Disease______ Diabetes______ Rheumatoid Arthritis______ None

SOCIAL HISTORY:

Do you use tobacco? Y N Packs per day_____

Marital Status S M D W

Occupation:____________________ Student

Do you like your job? Y N

Alcohol use? None Occasional Frequent Daily

How many people live with you? ________

Employer: ______________________________

Do you plan to be working 6 months from now? Y N

PLEASE SIGN: The information on these two pages is accurate to the best of my knowledge. ______________________________Date________

FOR OFFICE USE ONLY

Complete__________ Date__________ Provider Signature______________________________ Date__________