**Ehsan Saadat MD**
**Spine Surgery**
**New patient questionnaire**

**Today's date:** _____

**Patient name**: _____

**Date of birth**: _____ **Age**: _____ years **Sex:** *Male* *Female*

Primary care doctor name: _____

Primary care doctor phone: _____

Primary care doctor address: _____

_____

Referring doctor name: _____ ☐ check here if your primary doctor referred you

Referring doctor phone: _____

Referring doctor address: _____

_____

**SYMPTOMS**

**What is the problem that you are here for today?** _____

1. **This pain has been present for** (write number below)**:**

   _____ days _____ weeks _____ months _____ years

2. **Has the problem worsened?** *Yes* *No*
   **If yes, when did it worsen?** _____ **How did it worsen?** _____

3. **Circle the level of pain <u>today</u>** (0=none, 10=worst imaginable)

   *0* *1* *2* *3* *4* *5* *6* *7* *8* *9* *10*

4. **Level of pain <u>on worst day</u>** (0= none, 10=worst imaginable): _____

5. **Do your troubles limit you from normal daily activities?** *Yes* *No*

6. **Is the pain** (*circle):* *Constant* **or** *Comes and goes*

7. **Is the pain** (*circle all that apply):* *Sharp* *Dull* *Stabbing* *Aching* *Burning* *Stiffness*

8. **Does the pain shoot or radiate down arms or legs?** (*circle all that apply)***:**

   Right arm Left arm Right leg Left leg

**9. Do you have weakness?** (*circle all that apply)***:**

Right arm Left arm Right leg Left leg

**10. Do you have numbness?** (*circle all that apply)***:**

Right arm Left arm Right leg Left leg

**11. The pain is <u>worse</u> when** (*circle all that apply):*

*Sitting Standing Walking Bending Twisting Lying down*

**12. The pain is <u>better</u> when** (*circle all that apply):*

*Sitting Standing Walking Bending Twisting Lying down*

**13. Do you have trouble <u>standing</u> for a long time?** *Yes No*

If yes, for how many minutes? _____ minutes

**14. Do you have trouble <u>walking</u> for a long time?** *Yes No*

If yes, for how many minutes? _____ minutes

**15. Have you lost control of bowel or bladder?** *Yes No*

If yes, please describe: _____

**16. Do you drop things with your hands?** *Yes No*

**17. Do you have difficulty buttoning your shirts?** *Yes No*

**18. Do you have difficulty with balance when you walk?** *Yes No*

**19. Did an injury cause the current problems?** *Yes No*

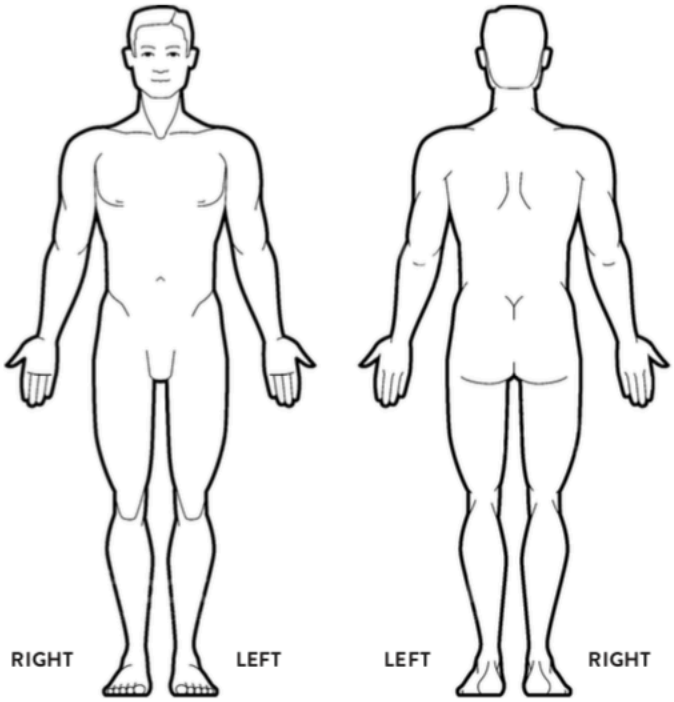
**Work-related?** *Yes No*

**Auto accident?** *Yes No*

**Other type of injury:** _____

**Date of injury:** _____

**Lawsuit pending?** *Yes No*




Where is your pain now?

Mark the areas on your body using the appropriate symbols to describe your symptoms.

| TYPE OF PAIN | SYMBOL |
|---|---|
| Ache | <<<<<<<<<<<<<< |
| Numbness | 0 0 0 0 0 0 0 0 0 |
| Pins & Needles | ▪▪▪▪▪▪▪▪▪▪▪▪▪▪▪▪▪▪ |
| Burning | xxxxxxxxxxxxxxx |
| Radiating Pain | /////////////////////////// |

How bad is your pain?

Neck Pain _____ %  Back Pain _____ %

Arm Pain _____ %  Leg Pain _____ %

Total 100 %  Total 100 %

How much pain in general can you tolerate?

0 1 2 3 4 5 6 7 8 9 10

How bad is your pain now?

0 1 2 3 4 5 6 7 8 9 10

**THE DURATION OF PAIN**

[ ] Continuous [ ] Positional [ ] Intermittent (On/Off) [ ] Unable to Rate

**HAVE YOU TAKEN PAIN MEDICATION IN THE PAST 24 HOURS?**

[ ] Yes [ ] No

**TREATMENT HISTORY FOR SPINE CONDITION:**

☐ check here if you have received no treatment for your problem so far

**Medications:**

Anti-inflammatories *No* *Yes (name and dose):* _____

Muscle relaxants *No* *Yes (name and dose):* _____

Narcotics *No* *Yes (name and dose):* _____

Other (name and dose): _____

**Have you had physical therapy?** *Yes* *No*
**If yes, did it help?** *Yes* *No* *A little*

**Have you had chiropractic care?** *Yes* *No*
**If yes, did it help?** *Yes* *No* *A little*

**Have you had acupuncture?** *Yes* *No*
**If yes, did it help?** *Yes* *No* *A little*

**Have you had injections?** *Yes* *No*
**If yes, circle what type and provide details:**

| | | | | | |
|---|---|---|---|---|---|
| Epidural | **date:** _____ | **Did it help?** | *Yes* | *No* | *A little* |
| | **date:** _____ | **Did it help?** | *Yes* | *No* | *A little* |
| | **date:** _____ | **Did it help?** | *Yes* | *No* | *A little* |
| Nerve block | **date:** _____ | **Did it help?** | *Yes* | *No* | *A little* |
| | **date:** _____ | **Did it help?** | *Yes* | *No* | *A little* |
| Facet block | **date:** _____ | **Did it help?** | *Yes* | *No* | *A little* |
| | **date:** _____ | **Did it help?** | *Yes* | *No* | *A little* |

**Other treatments:**

_____ _____

**Have you had spine surgery?** *Yes* *No*
If yes, please list details of all spine surgeries:

**Date:** _____ **Surgeon:** _____

**Surgery:** _____

**Date:** _____ **Surgeon:** _____

**Surgery:** _____

**List any medical conditions or diagnoses YOU have:**

High blood pressure? *Yes* *No*
Coronary artery disease? *Yes* *No*
Heart attack in the past? *Yes* *No*
Heart stents? *Yes* *No*
Bypass surgery? *Yes* *No*
Stroke in the past? *Yes* *No*
Atrial fibrillation? *Yes* *No*

Diabetes? *Yes* *No*
Do you take insulin? *Yes* *No*

Asthma? *Yes* *No*
COPD? *Yes* *No*

Liver problems? *Yes* *No*
Hepatitis B? *Yes* *No*
Hepatitis C? *Yes* *No*
HIV? *Yes* *No*

Kidney problems? *Yes* *No*
Dialysis? *Yes* *No*

Bleeding/clotting problems? *Yes* *No*
*Describe:*

Thyroid problems? *Yes* *No*

Cancer? *Yes* *No*

Osteoporosis? *Yes* *No*

Depression? *Yes* *No*
Anxiety? *Yes* *No*

**OTHER HEALTH PROBLEMS:** _____

**List ALL previous surgeries (spine and non-spine surgeries) with their dates**

_____ _____
_____ _____
_____ _____

**List ALL medications you take and their doses (including Aspirin, Coumadin, or any other blood thinners)**

_____ _____
_____ _____
_____ _____
_____ _____

**Any allergies to <u>medications</u> or <u>substances</u> (latex, contrast dye)?** *No* *Yes*

**If yes, please list your allergies:** _____

**Do you smoke?** *No* *If yes, how much:* _____

**Do you drink alcohol?** *No* *If yes, how much:* _____

**Do you use drugs?** *No* *Yes (please list):* _____

**Occupation:** _____ **Where do you work?** _____

# Current Review of Systems Medical Questionnaire

**Psychology**

| | |
|---|---|
| Depression | O Yes O No |
| High stress level | O Yes O No |
| Mood Swings | O Yes O No |
| Panic Attacks | O Yes O No |

**Musculoskeletal**

| | |
|---|---|
| Joint stiffness | O Yes O No |
| Joint pain | O Yes O No |
| Back Pain | O Yes O No |
| Prior Bone fracture | O Yes O No |
| Other Physical Limitations | O Yes O No |

**General**

| | |
|---|---|
| Weight gain | O Yes O No |
| Fever | O Yes O No |
| Night sweats | O Yes O No |
| Unexplained weight loss | O Yes O No |

**ENT**

| | |
|---|---|
| Hearing impairment | O Yes O No |
| Ringing in ears | O Yes O No |
| Scalp Tenderness | O Yes O No |

**Nervous System**

| | |
|---|---|
| Headache | O Yes O No |
| Weakness,Numbness,Tingling | O Yes O No |
| Dizziness | O Yes O No |

**Neurology**

| | |
|---|---|
| Stroke | O Yes O No |
| Seizures | O Yes O No |
| Gait Difficulties | O Yes O No |

**Digestive System**

| | |
|---|---|
| Ulcer Disease | O Yes O No |
| Diarrhea | O Yes O No |
| Vomiting/nausea | O Yes O No |
| Constipation | O Yes O No |
| Hepatitis | O Yes O No |
| Abdominal pain | O Yes O No |
| Reflux | O Yes O No |

**Dermatology**

| | |
|---|---|
| Rash | O Yes O No |
| Hives | O Yes O No |
| Mass/Tumors | O Yes O No |

**Endocrinology**

| | |
|---|---|
| Diabetes | O Yes O No |
| Thyroid Disease | O Yes O No |
| Hormonal Disease | O Yes O No |

**Respiratory**

| | |
|---|---|
| Asthma | O Yes O No |
| Lung Disease | O Yes O No |
| Breathing difficulty | O Yes O No |

**Genitourinary**

| | |
|---|---|
| Urinary Tract Infection | O Yes O No |
| Urinary Bleeding | O Yes O No |
| Altered Menses | O Yes O No |
| Uncontrolled Urination | O Yes O No |
| Kidney Disease | O Yes O No |

**Heart/Circulatory**

| | |
|---|---|
| Hypertension | O Yes O No |
| Chest pain | O Yes O No |
| Palpitations | O Yes O No |
| Pacemaker | O Yes O No |
| Heart Attack/Heart failure | O Yes O No |

**Blood**

| | |
|---|---|
| Bleeding Disorder | O Yes O No |
| Swollen Glands | O Yes O No |
| Anemia | O Yes O No |
| Blood Tumors/Disease | O Yes O No |

**Family History**

| | |
|---|---|
| Mother still living | O Yes O No |
| Father still living | O Yes O No |

Do you have children O No O 1 O 2
O 3 O 4 O More:___

**Patient Signature:** _____ **Date:** _____