

SPINE CLINIC MEDICAL QUESTIONNAIRE

Kalman D. Blumberg, M.D./Jeffrey B. Cantor, M.D.

NAME: _____ DATE: _____

AGE: _____ Right-Handed Left-Handed

Referring Physician: _____ Family Physician: _____

Reason for visit: _____

How did your injury occur: _____

1. Have you had similar back/neck problems in the past? Yes No

2. Approximately when did this episode of back, leg, neck, or arm pain start? _____

3. What were you doing when your symptoms started?

- Unsure Sitting Bending Lifting Walking
 Sports Accident Other _____

4. Please explain where your pain first started: Unknown Lower Back Upper Back

- Low Back Low Back & One Leg Low Back & Both Legs Leg or Legs Only
 Neck Neck & One Arm Neck & Both Arms Arm or Arms Only
 Other _____

5. How has your pain changed since it started? Improving No change

Worse in one or both legs Worse in back

6. What activities worsen your condition? _____

7. What relieves your symptoms? _____

PAST TREATMENT/EVALUATION OF YOUR CURRENT PROBLEM

Physical Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ice Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heat Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cortisone Injection	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Traction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back Support	<input type="checkbox"/> Yes	<input type="checkbox"/> No
TENS Unit	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chiropractic Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Acupuncture	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Home or Water Exercises	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epidural Injections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
X-Rays	<input type="checkbox"/> Yes	<input type="checkbox"/> No
CAT Scans	<input type="checkbox"/> Yes	<input type="checkbox"/> No
MRI	<input type="checkbox"/> Yes	<input type="checkbox"/> No
EMG/Nerve Study	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Tests	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Related Past Surgeries	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you have had spinal surgery, indicate what type:

1. _____

Surgeon: _____

Hospital: _____

When: _____
Month/Year

2. _____

Surgeon: _____

Hospital: _____

When: _____
Month/Year

3. _____

Surgeon: _____

Hospital: _____

When: _____
Month/Year

Continued on back

MEDICAL HISTORY

Medications to Which You Are Allergic: _____

Medications You Are Presently Taking: _____

Do you have a history of the following?

- Yes No Cancer: (Location) _____
(Type) _____
- Yes No Diabetes
- Yes No High blood pressure
- Yes No Heart disease
- Yes No Mitral valve prolapse
- Yes No Phlebitis
- Yes No Liver disease
- Yes No Peptic ulcers
- Yes No Anemia
- Yes No HIV or AIDS
- Yes No Kidney disease
- Yes No Asthma
- Yes No Epilepsy
- Yes No Glaucoma
- Yes No Thyroid disease
- Yes No Arthritis
- Yes No Polio
- Yes No History of blood transfusions
- Yes No Any family history of current problems

Are you experiencing any of the following symptoms?

- Fever
- Fatigue
- Double vision
- Hearing problems
- Shortness of breath
- Blood in urine
- Varicose veins
- Ankle swelling
- Abdominal pain
- Frequent bladder infections
- Skin changes/rashes
- Migraine headaches
- Insomnia
- Vertigo
- Anxiety requiring medication
- Swollen glands
- Frequent bruising
- Sexual dysfunction
- Hepatitis

List any other past surgeries (include dates): _____

SOCIAL HISTORY:

Occupation: _____ Active Retired

Primary Language: _____

Alcohol Use: None Rare Social Frequent

Smoking History: Nonsmoker

Current Smoker : ____ ¼ pack per day ____ ½ pack per day ____ packs per day

Previous smoker (How long ago did you quit) _____

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DATE: _____