

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?

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

Are you experiencing any of the following symptoms?

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

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 : _____ pack per day _____ pack per day _____ packs per day

Previous smoker (How long ago did you quit) _____

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DATE: _____