Premier Orthopedics of Virginia
HCAVa Physicians
AN HCA AFFILIATE

NEW PATIENT FORM

Spine, Hip, Neck & Shoulder

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Please **completely** fill in the appropriate boxes.

Appointment Date: _____

Patient Name (Print): _____ **Date of Birth**:_____ **Age:** _____

Who referred you? (Name) _____ []MD []Other Healthcare provider []Attorney []no one

What part of the spine is involved: [] Neck [] Back [] other:_____ Did you bring? **Xrays** []Yes [] No **MRI** []Yes []No

What is the **main reason** for this visit? []Pain []Numbness []Weakness []Swelling []Stiffness []Other_____

When did it start? (Date)_____ Have you had a problem like this before? If so, when? _____

In this section, check the **ONE BOX** that best describes how your problem started. Then answer the questions below the box you checked. Use as much as space to the right as needed to describe your problem

[ ] **NO INJURY** (onset was []Gradual or []Sudden)?

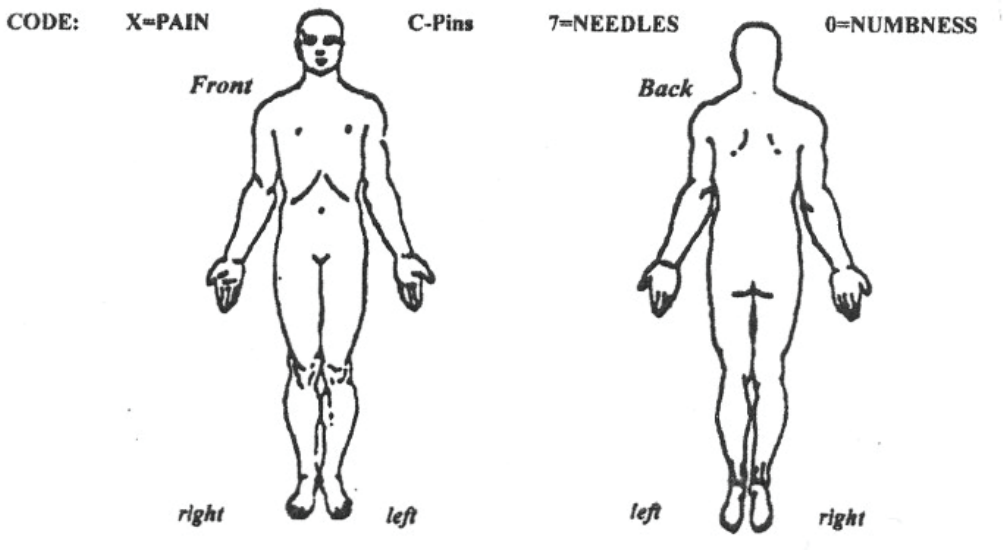
Why do you think it started?

[ ] **INJURY** ([]accident []sport []auto []work)

Date_____ Where and how did it happen?

ANSWERS/COMMENTS:_____
_____
_____
_____
_____

- Have you had spinal surgery in the past: [] Yes [] No
  What was the surgery? (check all): [] Diskectomy [] Laminectomy [] Fusion []Other _____
- What spinal level(s)? _____What was the date of your most recent spine surgery? _____
- Did you improve from your spine surgery procedure? [] Yes [] No:_____
- On a scale of 1-10 (10 worst), how is your pain **now**? (Circle) 0 1 2 3 4 5 6 7 8 9 10 the worst ever
- **Please describe your pain on the diagram below:**



- **Where is this problem located (check all that apply):** [] Neck [] Upper Back [] Arm [] Lower back [] Hip [] Leg
- **What is the quality of your pain?** [] sharp [] dull [] stabbing [] throbbing [] aching [] burning

- **The pain is:** []constant []comes and goes **Does it wake you from sleep?** []Yes []No
- **Do you have** [] swelling [] bruising [] numbness [] tingling [] weakness [] loss of control of bowel/bladder
- **Is the problem getting** [] better [] worse [] unchanged
- **Which of the following best describes your ratio for neck/arm or back/leg discomfort (if appropriate)? (circle one)**

100% back pain and 0% leg pain	100% neck pain and 0% arm pain
90% back pain and 10% leg pain	90% neck pain and 10% arm pain
75% back pain and 25% leg pain	75% neck pain and 25% arm pain
50% back pain and 50% leg pain	50% neck pain and 50% arm pain
25% back pain and 75% leg pain	25% neck pain and 75% arm pain
10% back pain and 90% leg pain	10% neck pain and 90% arm pain
0% back pain and 100% leg pain	0% neck pain and 100% arm pain

- **Please choose one of the following for each of the activities below:**

	Aggravates Pain	**Relieves Pain**	**Does Nothing**
Sitting	□	□	□
Standing	□	□	□
Walking	□	□	□
Leaning Forward	□	□	□
Bending forward	□	□	□
Lying on your side	□	□	□
Lying on your back	□	□	□
Lying on your stomach	□	□	□
Rising from sitting	□	□	□
Coughing/Sneezing	□	□	□

- **Of the following list of treatments, please indicate if you have tried and the effect of those which have been used in an attempt to help your present injury: (Check one of each)**

	Helpful	**Was Not Helpful**	**Have not used**
Anti-inflammatory	□	□	□
Muscle relaxants	□	□	□
Narcotic Pain Medications	□	□	□
Hot packs	□	□	□
Ice	□	□	□
Ultrasound	□	□	□
TENS unit	□	□	□
Physical therapy	□	□	□
Chiropractor	□	□	□
Epidural block/Injection	□	□	□
Facet block/Injection	□	□	□
Trigger point Injection	□	□	□
Acupuncture	□	□	□
Traction	□	□	□

- If you had an epidural injection(s), what was the total number? _____ When was the last one?_____
- If the epidural injection was helpful, <u>what percentage of your pain</u> went away? (0-100%) _____%
- Please indicate if you have had any of the following studies, write when/where the most recent was (circle all)

Regular X-ray of spine	**CT Scan of Spine**	**MRI of Spine**	**EMG**
Bone Scan	**Myelogram**	**Discogram**	**Bone Density**

- Current work status? [] Regular [] Light duty (How long?_____) [] Disabled
  [] Student [] Not working due to this problem [] Retired

- If not working, when was the last date you worked a regular job? _____
- Are you currently receiving or plan to apply for:
  Disability []Yes []No Workman's Comp []Yes []No Unemployment []Yes []No

SCREENING PAST MEDICAL HISTORY QUESTIONAIRE:

- **Do you currently have or do you have a history of any of the following conditions? If yes, please list date:**

Allergic Reaction	□ Yes	□ No
Anemia	□ Yes	□ No
Anorexia/Bulemia	□ Yes	□ No
Arthritis	□ Yes	□ No
Asthma/Breathing Difficulties	□ Yes	□ No
Bowel/Bladder Difficulties	□ Yes	□ No
Cancer	□ Yes	□ No
Chest Pain/Angina	□ Yes	□ No
Circulation Disorders	□ Yes	□ No
Depression/Psychiatric Disorder	□ Yes	□ No
Diabetes	□ Yes	□ No
Dizziness/Fainting	□ Yes	□ No
Foot Ulcers	□ Yes	□ No
Fractures	□ Yes	□ No
HIV	□ Yes	□ No
Headaches	□ Yes	□ No
Heart Disease or Heart Attack	□ Yes	□ No
Heart Palpitations/Arrhythmias	□ Yes	□ No
Hepatitis	□ Yes	□ No
Hernia	□ Yes	□ No
High Blood Pressure	□ Yes	□ No
Kidney Problems	□ Yes	□ No
Liver/Gall Bladder Problems	□ Yes	□ No
Lung Disease	□ Yes	□ No
Malnutrition	□ Yes	□ No
Metal Implants	□ Yes	□ No
Osteoporosis	□ Yes	□ No
Pacemaker	□ Yes	□ No
Pregnancy (currently)	□ Yes	□ No
Problems with Eyesight/Hearing	□ Yes	□ No
Pulmonary Embolism	□ Yes	□ No
Seizures	□ Yes	□ No
Skin Abnormalities	□ Yes	□ No
Stomach Ulcers	□ Yes	□ No
Stroke/Transient Ischemic Attack	□ Yes	□ No
Substance Abuse	□ Yes	□ No
Thyroid Problems	□ Yes	□ No

Please list any other current medical problems here:

_____

_____

- **SURGICAL HISTORY (Please list all surgeries and hospitalizations here with dates)**

  _____

  _____

Any surgical complications?_____

- **FAMILY HISTORY:** _____

  _____

- **MEDICATIONS:** _____

  _____

  _____

  _____

  Are you are currently taking: [] Coumadin/Warfarin [] Plavix [] Aspirin

- **ALLERGIES: Are you allergic to any of these? (please check):** []None []Penicillin []Sulfa []Codeine []Aspirin []Latex []Food:_____

- **SOCIAL HISTORY:**

  Marital status: [] Single [] Married [] Divorced [] Widowed [] Separated

  Occupation (if retired, list former job)_____

  Smoker: [] No [] Yes____pack(s) per_____ [] Quit _____ years ago

  Alcohol: [] None [] Yes (How much and how often?) _____

  Any history of drug use: [] no [] yes: _____(any IV Drug use? [] No [] Yes:_____)

- **REVIEW OF SYSTEMS:** Do you **currently** experience any of the following? **Check here if none apply []**

General	**Cardiovascular**	**Gastrointestinal**	**Musculoskeletal**	**Neurologic**
[] Weight loss [] Fever [] Fatigue [] Night sweats	[] Chest [] Irregular Rhythm [] Heart Murmur	[] Heartburn w/aspirin [] Stomach ulcers [] Hepatitis	[] Arthritis [] Osteoporosis [] Prior Fracture	[] Balance Problems [] Dizziness [] Weakness [] Headaches [] Seizures
Eyes	**Ears/Nose/Throat**	**Respiratory**	**Urinary**	**Endocrine**
[] Glasses [] Contacts [] Glaucoma	[] Hearing loss [] Sinus Infection [] Hoarseness	[] Shortness of Breath [] Sleep Apnea	[] Painful Urination [] Urinary Infection	[] Thyroid Problems [] Diabetes
Skin	**Hematologic**	**Immunologic**	**Psychiatric**	
[] Rashes [] Psoriasis	[] Bleeding Problems [] Blood clots	[] Tuberculosis [] HIV infection	[] Depression [] Anxiety	

- **Women only:** Pregnant [] Yes [] No

To the best of my knowledge, the information provided on pages 1-4 is accurate. Please sign and date below

_____ _____

Patient or Responsible Party Signature **Date**

**********BELOW: OFFICE USE ONLY**********

Height: _____ **Weight: _____** **HR:_____** **BP:_____** Temp:_____ Pulse Ox:_____

_____ _____

MD Signature (acknowledging review of pages 1-4) **Date**