

Patient Name: _____

DOB: _____

MR #: _____

Date: _____

University of Wisconsin Hospital and Clinics

600 Highland Avenue • Madison, Wisconsin 53792

INITIAL PATIENT QUESTIONNAIRE – SPINE

(BRING THIS QUESTIONNAIRE WITH YOU TO YOUR APPOINTMENT. DO NOT MAIL)

Mark in the areas of your body where you now feel your typical pain. Include all affected areas. Use the appropriate symbols indicated below: PAIN = XXXXXX NUMBNESS = OOOOOO

FRONT

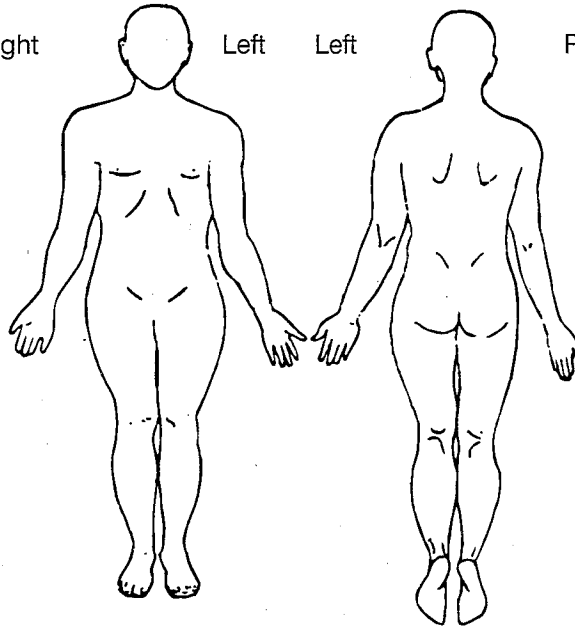
BACK

Right

Left

Left

Right



If more than one area, which is worse? _____

How long have you had this problem? _____

Did your symptoms follow an injury? _____ If yes; _____ at work _____ auto accident _____ other

Describe: _____

Circle your least and greatest pain levels over the past two weeks:

(None) 0---1---2---3---4---5---6---7---8---9---10 (Severe)

Have you had neck/back symptoms before? Y___ N___

Have you ever had previous back or neck surgery? Y___ N___

If yes, describe: _____

Is the purpose of this exam to determine disability status for the government or an insurance agency? _____

Are you currently receiving any type of financial compensation for your back problem? _____

Do you have an attorney for your back problem? _____

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Please list previous radiology studies you have had for this problem.

Date

Location

MRI _____

CT Scan _____

Myelogram _____

Bone Scan _____

EMG _____

X-rays _____

PREVIOUS TREATMENT:

Put a check next to each type of treatment you have had for you back/neck in the past. Then check the column that best describes the effect of the treatment.

<u>Treatment</u>	Check if you have had this	Did it make things		
		<u>Better</u>	<u>Worse</u>	<u>No change</u>
Hot packs/ice	_____	_____	_____	_____
Ultrasound	_____	_____	_____	_____
Massage	_____	_____	_____	_____
TENS/E-Stim	_____	_____	_____	_____
Yoga/Tai-Chi	_____	_____	_____	_____
Exercises	_____	_____	_____	_____
Traction	_____	_____	_____	_____
Bed Rest	_____	_____	_____	_____
Pool therapy	_____	_____	_____	_____
Biofeedback	_____	_____	_____	_____
Injections	_____	_____	_____	_____
Braces/Splints	_____	_____	_____	_____
Medication	_____	_____	_____	_____
Acupuncture	_____	_____	_____	_____
Chiropractic Adjustments	_____	_____	_____	_____

MEDICAL HISTORY:

Have you ever had:

- | | | | |
|--|------------------------------|-------------------|----------------------|
| ___ AIDS or HIV testing | ___ Phlebitis or blood clots | ___ Kidney Stones | ___ GERD |
| ___ Asthma/Breathing problems | ___ Stroke | ___ Arthritis | ___ High Cholesterol |
| ___ Cancer | ___ Thyroid trouble | ___ Seizures | |
| ___ Radiation/Chemotherapy | ___ Kidney Infections | ___ Ulcer | |
| ___ Migraine or other severe head pain | ___ Heart Disease | ___ Tuberculosis | |
| ___ High Blood Pressure | ___ Diabetes | ___ Hepatitis | |
| ___ Chronic Fatigue Syndrome | ___ Fibromyalgia | ___ Other: _____ | |

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REVIEW OF SYSTEMS:

Check all that apply.

Constitutional

Fever____
Chills____
Night sweats____
Weight loss____
Loss of appetite____

Allergy/immune

Drug allergy____
Seasonal allergy____
Food allergy____
Iodine allergy____
Transplant____

Neurologic

Paralysis____
Tremors____
Spasticity____
Seizures____
Muscle atrophy____
Double vision____

Musculoskeletal

Joint stiffness/swelling____
Muscle pain/swelling____
Fatigue____
Fractures____

Hemolymphatic

Anemia____
Excessive bleeding____
Easy bruising____
Lymphoma____
Leukemia____
Cancer____
Lymph node swelling____

CV/Respiratory

Shortness of breath____
Wheezing____
Cough____
Coughing up blood____
Chest pains____
Palpitations____
Leg swelling____

Gastrointestinal

Difficulty swallowing____
Heartburn____
Nausea/vomiting____
Constipation____
Diarrhea____
Blood in stools____
Stomach pain____

Endocrine

Obesity____
Thyroid disorder____
Diabetes____
Menopause____
Menstrual irregularities____
Pelvic Pain____
Addison's disease____

HEENT

Loss of vision____
Eye Redness____
Headaches____
Dizziness____
Glaucoma____

Skin/integumentary

Rash____
Ulcer____
Eczema____
Hives____
Sexual Difficulties____

Genitourinary

Pain urinating____
Incontinence____
Blood in urine____
Dribbling____
Pregnant____
Last Menstrual Period (date)____

Psychiatric

Poor sleep____
Depression____
Anxiety____
Stress at work/home____

PAST SURGICAL HISTORY:

Year	Operation	Place Hospitalized

ALLERGIES:

Name of medicine/substance	Type of reaction	Date

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MEDICINES: List all medicines that you take, including the doses and how often you take them. Include vitamins and nonprescription medicine.

1. _____
2. _____
3. _____
4. _____

5. _____
6. _____
7. _____
8. _____

FAMILY HISTORY:

Spinal Problems Y__ N__ If yes, describe: _____
Bleeding Disorders Y__ N__ If yes, describe: _____
Heart Disease Y__ N__ If yes, describe: _____
Cancer Y__ N__ If yes, describe: _____
Diabetes Y__ N__ If yes, describe: _____

SOCIAL HISTORY:

How many years of schooling? (circle one)

Less than high school high school graduate technical school diploma 1-3 years of college
College graduate post graduate or professional degree

Marital Status: Single__ Married__ Divorced__ Remarried__ Widowed__ Separated__

Who lives with you at home? _____

Work status: Working__ Not Working__ Student__ Disabled__ Retired__

Primary Occupation: _____ Employer: _____

How long have you worked at your present job? _____ If not working, last date worked: _____

Have you ever smoked? _____ Type/Amount: _____ Years: _____ If quit, when? _____

Amount of alcohol consumed in a typical week? _____ Cups of caffeinated drinks per day? _____

Have you used: Marijuana _____ Cocaine _____ Heroin _____ Other _____

Do you get any regular exercise? Describe: _____

Completed by: _____ Date: _____
If not completed by patient, relationship to patient: _____
Reviewed by: _____ Date: _____ Time: _____