Patient Name

DOB:

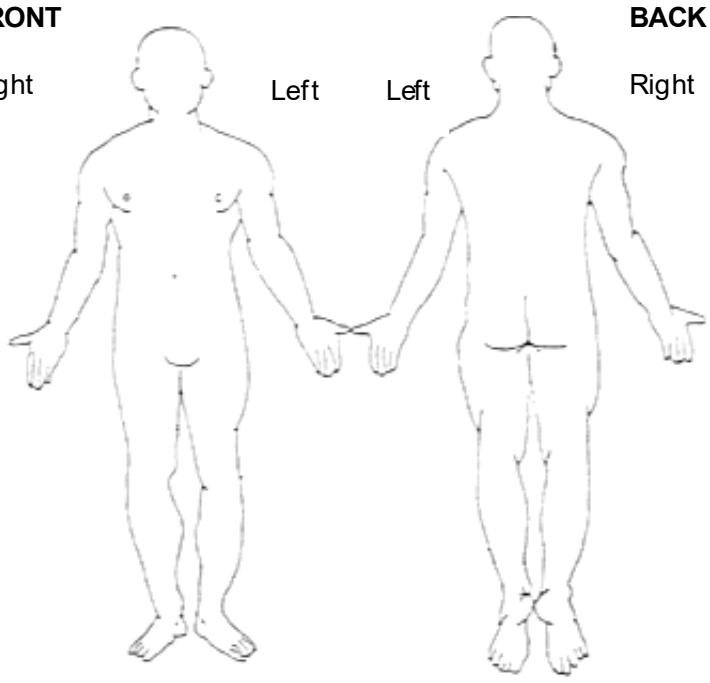
MR #

UW Health
(University of Wisconsin Hospitals and Clinics Authority)
INITIAL PATIENT QUESTIONNAIRE – SPINE

Index to Questionnaire – Health\Encounter
Date: _____

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



1. If more than one area, which is worse? _____
2. How long have you had this problem? _____
3. Did your symptoms follow an injury? □ Yes □ No 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)
4. Have you had neck/back symptoms before? □ Yes □ No
5. Have you ever had previous back or neck surgery? □ Yes □ No
   If yes, describe: _____
6. Is the purpose of this exam to determine disability status for the government or an insurance agency? □ Yes □ No
7. Are you currently receiving any type of financial compensation for your back problem? □ Yes □ No
8. Do you have an attorney for your back problem? □ Yes □ No

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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 your back/neck in the past. Then check the column that best describes the effect of the treatment.

Treatment	Check if you have had this	Did it make things Better	Worse	No change
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**	(✓)	**Allergy/immune**	(✓)	**Neurologic**
	Fever		Drug allergy		Paralysis
	Chills		Seasonal allergy		Tremors
	Night sweats		Food allergy		Spasticity
	Weight loss		Iodine allergy		Seizures
	Loss in appetite		Transplant		Muscle atrophy
(✓)	**Hemolymphatic**	(✓)	**CV/Respiratory**		Double vision
	Anemia		Shortness of breath	(✓)	**Gastrointestinal**
	Excessive bleeding		Wheezing		Difficulty swallowing
	Easy bruising		Cough		Heartburn
	Lymphoma		Coughing up blood		Nausea/vomiting
	Leukemia		Chest pains		Constipation
	Cancer		Palpitations		Diarrhea
	Lymph node swelling		Leg swelling		Blood in stools
(✓)	**HEENT**	(✓)	**Skin/Integumentary**		Stomach pain
	Loss of vision		Rash	(✓)	**Genitourinary**
	Eye redness		Ulcer		Pain urinating
	Headaches		Eczema		Incontinence
	Dizziness		Hives		Blood in urine
	Glaucoma		Sexual difficulties		Dribbling
(✓)	**Musculoskeletal**	(✓)	**Endocrine**		Pregnant
	Joint stiffness/swelling		Obesity	(✓)	**Psychiatric**
	Muscle pain/swelling		Thyroid disorder		Poor sleep
	Fatigue		Diabetes		Depression
	Fractures		Menopause		Anxiety
			Menstrual irregularities		Stress at work/home
			Pelvic pain		
			Addison's disease		

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 medicines.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

FAMILY HISTORY:

Spinal problems □ Yes □ No If yes, describe: _____
Bleeding Disorders □ Yes □ No If yes, describe: _____
Heart Disease □ Yes □ No If yes, describe: _____
Cancer □ Yes □ No If yes, describe: _____
Diabetes □ Yes □ No If yes, describe: _____

SOCIAL HISTORY

How many years of schooling? (check 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? □ Yes □ No 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: _____

Signature of Patient/Representative: _____ Date: _____/_____/_____Time: _____

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: _____ Relationship: _____

- Patient is: ☐ Minor ☐ Incompetent/Incapacitated
- Legal Authority: ☐ Legal Guardian ☐ Parent of Minor
  ☐ Health Care Agent ☐ Other: _____

Reviewed by: _____ Date: _____/_____/_____Time: _____