## Denver Spine Surgeons - SPINE Health History Page 1 of 4

Please circle M.D. you are seeing today.

**David A. Wong, M.D.**

**PATIENT NAME**_____ **DOB**_____ **Age**_____
**Soc Sec #**_____ **Today's Date**_____
**Referred By**_____

**PRESENT INJURY OR PROBLEM**

**What is the location of your spine pain? (Circle One)**

Neck Mid Back Low Back

**IF NECK PAIN**

**Most of my pain is in my neck** _____
OR
**Most of my pain is in my arm(s)** _____
OR
**I have equal amounts of pain in my neck and arm(s)**
_____

**I have also experienced**
**Hand numbness/tingling** _____
**Hand weakness** _____
**Hand clumsiness** _____

**IF LOW BACK PAIN**

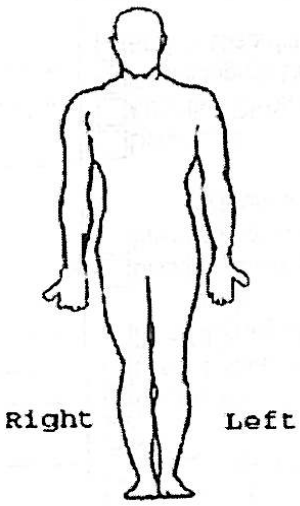
**Most of my pain is in my back** _____
OR
**Most of my pain is in my leg(s)** _____
OR
**I have equal amounts of pain in my back and leg(s)**
_____

**I have also experienced**
**Leg/foot numbness/tingling** _____
**Leg/foot weakness** _____
**Leg/Foot clumsiness of gait** _____

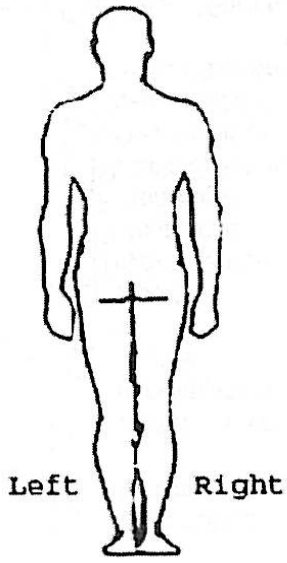
**Would you be so kind as to draw your pain location (today) on the diagram below.**

**Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Please include all affected areas.**

**PAIN/ACHE – XXXXX NUMBNESS - ====== PINS AND NEEDLES – 00000**




**FRONT**




**BACK**

What activities increase your pain?

Standing _____

Sitting _____

Walking _____

Driving _____

Bending _____

Other-List_____

_____

Do you have pain when trying to sleep? Yes _____ No _____

Have you had any upset in bladder function?

Yes _____ No _____

Have you had any upset in bowel function?

Yes _____ No _____

**Please proceed to next page.**

**PATIENT NAME**

ONSET: **When did your symptoms first start?**_____**/**_____**/**_____
**Was the onset** Sudden **or** Gradual
**Have you had problems like this before? No Yes If Yes, When** _____**/**_____**/**_____
**When did you first seek medical care for this problem?** _____**/**_____**/**_____

**What caused your symptoms? (Circle One)** INJURY DON'T KNOW OTHER:_____

**If an injury, was it (Circle One)** Work Related Auto Accident Fall Lifting _____

PAIN**: How would you rate your pain – scale of 0-10 if *0 is no pain and 10 is intolerable*, as bad as it can be?**

**On a bad day** _____ **On a good day** _____ **Today** _____

ACTIVITY LEVEL: **How would you rate your activity level now? (Circle one)**
1. **I am able to do whatever activities I choose.**
2. **I have to be careful or cautious about what activities I do**
3. **I have several restrictions in my lifestyle at work or at home.**

**Work Status (Circle One)** OCCUPATION_____
1. **I am not employed. (Homemaker, student, retired, unemployed…)**
2. **I am working; this problem hasn't affected my work.**
3. **I am working less because of this problem – approximately** _____**% less.**
4. **I am working with some restrictions.**
5. **I have been off work since** _____**/**_____**/**_____
6. **I have been disabled since**_____**/**_____**/**_____
7. **How much work have you missed in the past year due to this problem?** _____**days**
8. **Is this a Worker's Compensation injury/problem? Yes / No**
9. **Is there an attorney involved with this injury/problem? Yes / No**

**PREVIOUS TREATMENT FOR THIS INJURY/PROBLEM**

| **X-rays/Tests for this problem:** | **Date** | **Where were they done?** | **Did you bring the films or have them sent to us?** |
|---|---|---|---|
| **Plain x-ray** | _____/_____/_____ | | |
| **MRI** | _____/_____/_____ | | |
| **CT Scan** | _____/_____/_____ | | |
| **Discogram** | _____/_____/_____ | | |
| **Other** | _____/_____/_____ | | |

**Medications for this problem: (Pain pills, anti-inflammatories)**

| **Medicine Type** | **How Much** | **How Often** | **Results** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Injections for this problem: (nerve root injections, epidural steroid injections)**

| **Injection Type** | **Date** | **Results** |
|---|---|---|
| | | |
| | | |

**Surgeries for this problem or in this area: How many**_____ **or None?**

| **Date** | **Surgery Type** | **Surgeon** | **Kind of Doctor** |
|---|---|---|---|
| ____/_____ | | | |
| ____/_____ | | | |

Other Treatments/**and date** **Physical Therapy**_____**/Chiropractor**_____**/Brace**_____**/**

**TENS unit**_____**/Acupuncture**_____**/Exercises**_____**/Massage**_____**/**

**Other**_____

**Please proceed to next page.**

**PATIENT NAME**

**Please Tell Us About YOUR Present Health Status**

**The following is a list of symptoms/illnesses. Indicate with a check whether you now have or have had in the past, any of these symptoms/illnesses. Please** LEAVE BLANK **spots for any which** DO NOT **relate to you.**

| Past | Present | | Past | Present | |
|---|---|---|---|---|---|
| | | CARDIOVASCULAR | | | NERVOUS SYSTEM |
| ____ | ____ | **High Blood Pressure** | ____ | ____ | **Epilepsy/Seizures** |
| ____ | ____ | **Chest Pain (Angina)** | ____ | ____ | **Dizzy/Fainting Spells** |
| ____ | ____ | **Heart Attack** | ____ | ____ | **Headaches** |
| ____ | ____ | **Heart Failure** | ____ | ____ | **Migraine Headaches** |
| ____ | ____ | **Heart Murmur** | ____ | ____ | **Neuropathy** |
| ____ | ____ | **Heart Valve Problems/Stents ___Y ___N** | ____ | ____ | **Loss of Balance** |
| ____ | ____ | **Stroke/TIA** | ____ | ____ | **Pain/tingling with neck motion** |
| ____ | ____ | **Blood Clots in legs/Blood Clots in the lungs** | | | |
| ____ | ____ | **Swelling in legs** | | | BLOOD DISORDERS |
| ____ | ____ | **Phlebitis** | ____ | ____ | **Anemia** |
| ____ | ____ | **Irregular heart beat/Arrhythmia** | ____ | ____ | **Sickle-cell anemia** |
| ____ | ____ | **Pacemaker** | ____ | ____ | **Hemophilia** |
| ____ | ____ | **High Cholesterol** | | | |
| | | PULMONARY | | | |
| ____ | ____ | **Asthma** | | | JOINT DISEASE |
| ____ | ____ | **Chronic bronchitis** | ____ | ____ | **Previous sciatica/back problems** |
| ____ | ____ | **Emphysema** | ____ | ____ | **Arthritis** |
| ____ | ____ | **Tuberculosis** | ____ | ____ | **Degenerative Joint Disease** |
| ____ | ____ | **Pneumonia** | ____ | ____ | **Joint replacement** |
| ____ | ____ | **Chronic pulmonary Disease (COPD)** | ____ | ____ | **Gout** |
| ____ | ____ | **Shortness of breath** | ____ | ____ | **Fractures of bone(s)** |
| ____ | ____ | **Sleep Apnea/CPAP ___Y ___N** | | | |
| | | | | | URINARY SYSTEM |
| | | GASTROINTESTINAL SYSTEM | ____ | ____ | **Bladder/kidney infections** |
| ____ | ____ | **Ulcers/GI bleeding** | ____ | ____ | **Kidney stones** |
| ____ | ____ | **Stomach irritation/heartburn** | ____ | ____ | **Loss of control of urine** |
| ____ | ____ | **Hiatal hernia** | ____ | ____ | **Enlarged prostate/urine flow problems** |
| ____ | ____ | **Gallbladder problems** | | | |
| ____ | ____ | **Liver disease/hepatitis** | | | INFECTIOUS DISEASE |
| ____ | ____ | **Black tarry stools/rectal bleeding** | ____ | ____ | **Hepatitis** |
| ___ | ____ | **Diverticulosis** | ____ | ____ | **AIDS or positive HIV** |
| ____ | ____ | **Hernia** | ____ | ____ | **Sexually transmitted disease** |
| | | | ____ | ____ | **Polio** |
| | | ENDOCRINE SYSTEM | ____ | ____ | **Herpes** |
| ____ | ____ | **Diabetes** | ____ | ____ | **Rheumatic fever** |
| ____ | ____ | **Thyroid disease** | ____ | ____ | **Scarlet fever** |
| ____ | ____ | **Addison's/Cushing's disease** | ____ | ____ | **Malaria** |
| | | | | | CANCER |
| | | SKIN/MISC | ____ | ____ | **Head/Neck/Thyroid** |
| ____ | ____ | **Eczema** | ____ | ____ | **Blood/bone** |
| ____ | ____ | **Psoriasis** | ____ | ____ | **Breast/Lung** |
| ____ | ____ | **Lupus** | ____ | ____ | **Skin** |
| ____ | ____ | **Fibromyalgia** | ____ | ____ | **Bowel/Kidney** |
| ____ | ____ | **Bruise easily** | ____ | ____ | **Prostate** |
| | | | ____ | ____ | **Other** |
| | | OB GYN | | | |
| ____ | ____ | **Fibroids** | | | PSYCHOLOGICAL DISORDERS |
| ____ | ____ | **Endometriosis** | ____ | ____ | **Depression** |
| ____ | ____ | **Tubes Tied** | ____ | ____ | **Nervous Disorder** |
| ____ | ____ | **Ovarian Cysts** | ____ | ____ | **Addictive Disorder (Drugs/Alcohol)** |
| ____ | ____ | **Post Menopause** | ____ | ____ | **Eating Disorder** |

**ALLERGIES** (list below)

**Food:** _____

**Medicine:** _____

_____

Other Health Problems (list below)

**not listed:** _____

_____

_____

**Do you feel chronically fatigued? Yes No**

**Please proceed to next page.**

**PATIENT NAME**

**Age_____ Height_____ Weight_____ Are you ____left hand/____right handed?**
**Have you experienced unexplained weight loss in the past year? ____ Yes ____ No How much?_____**
**Have you experienced any unexplained weight gain in the past year? _____Yes _____ No How much?_____**

**Do you use tobacco? ____ Yes ____ No; If yes, how much?_____**
**____ Quit How long ago?_____**
**Do you drink alcohol? ____ Yes ____ No If yes, how much?_____**
**____ Quit How long ago?_____**
**Recreational drug use? ____ Yes ____ No If yes, how much?_____**
**____ Quit How long ago?_____**

**Please list all surgeries and hospitalizations you have had and the year they took place.**

**Have you ever had a blood transfusion? _____Yes _____No When_____**
**Have you had any *anesthetic* problems such as _____Difficulty inserting breathing tube,**
**_____High fever during or after anesthesia**
**_____Significant nausea or vomiting after surgery**
**_____Other (list)**

**Please list all current medications, strength, and how often you take them. List even those medications that do not need a prescription.**

**For your SPINE problem** **For OTHER health problems.**

**List any herbal medications you have used.**

**FAMILY HISTORY**

**Please circle any health problems diagnosed in your immediate family and note who:**

| Condition | Who | Condition | Who | Condition | Who |
|---|---|---|---|---|---|
| Arthritis/Rheumatism | _____ | Liver problems | _____ | Hypertension | _____ |
| Sciatic/back problems | _____ | Cancer | _____ | Heart Attack | _____ |
| Breathing problems | _____ | Diabetes | _____ | Angina | _____ |
| Bleeding problems | _____ | Kidney Disease | _____ | Other | _____ |

**Is there anything else you feel the doctor should know about your lifestyle or medical history?**

*Sorry the form took so long to fill out but it really helps us.*
*Thank you* **for helping us to help you. David A Wong, M.D.**