

St. Peters Bone & Joint Surgery

GENERAL ORTHOPEDICS • SPINE • SPORTS MEDICINE
FOOT & ANKLE SURGERY • JOINT REPLACEMENT • HAND SURGERY

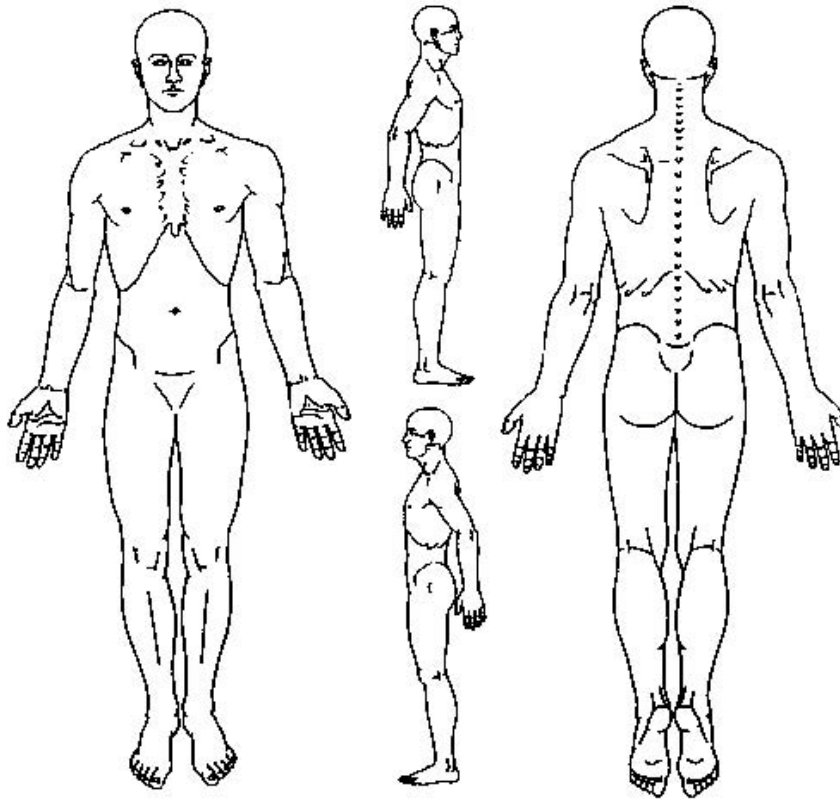
Spine Form

Date: _____

Date of Birth #: _____

Patient Name: _____ Age: _____ Height: _____ Weight: _____

1. Please indicate you areas of pain on the figures below with X's. Please indicate your areas of numbness and tingling on the figures below with O's.



2. How long have you had the problem(s)? _____

3. How have your symptom(s) changed over time? Better ___ Same ___ Worsened ___

4. What happened to produce the symptoms? _____

5. If the problem is from an accident, please explain: _____

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6. Where is your pain primarily located? Neck _____ Arms _____ Back _____ Legs _____
7. Choose one of the following descriptions of your pain on an average day?
- Pain in my neck is more severe than pain in my arms or hands
 - Pain in my arms/hands is more severe than in my neck
 - Pain in my back is more severe than the pain down my legs/feet
 - Pain down my legs /feet is more severe than the pain in my back
8. What activates make your pain worse? Lying _____ Standing _____ Coughing _____ Bending _____
Lifting _____ Sneezing _____ Sitting _____ Walking _____
9. What activities help you pain? Rest _____ Exercise _____ Sitting _____ Lying down _____
Meds _____ Others: _____
10. What type of job & on the job activities do you routinely perform? _____

11. How much time have you been off work dues to your problem? _____
12. Has any other doctor treated you for this condition? Yes _____ No _____
- If yes, who _____
13. Have you ever been placed in a brace for this condition? Yes _____ No _____
14. Have you had any physical therapy or chiropractic care as part of your treatment? Yes _____
No _____ If Yes, where _____
15. Have you developed any difficulty with your control of urine &/or bowel movements? (Do you have accidents on yourself?) Yes _____ No _____
16. Have you received an Epidural Steroid Block for neck, back, arm, or leg pain? Yes _____
(How many _____) by which doctor(s) _____ No _____
17. How do you rate your pain on a scale of 0-10 (0 - no pain, 10 worst pain)
- | | |
|--------------------------|-------------------------|
| Neck Pain _____/10 daily | Arm Pain _____/10 daily |
| Back Pain _____/10 daily | Leg Pain _____/10 daily |
18. Have you ever been told you have problems with your liver or kidneys? Yes _____ No _____

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19. Have you ever been told you have (or had) Hepatitis or HIV/Aids? Yes _____ No _____
If yes, do you know how you contracted the disease? _____

20. Have you ever been diagnosed by a doctor with a Medical Condition? Yes _____ No _____
If yes, explain condition(s)? _____

21. Have you ever had any surgeries? Yes _____ No _____ If Yes, Please list each
procedure and Doctor. _____

22. Have you ever had any Spinal surgeries? Yes _____ No _____ If Yes, Please
Explain _____

23. Please list **all** daily medications you are currently taking for medical problems. _____

24. Do you have any allergies to foods or medications? Have you ever had any surgeries? Yes _____
No _____ If Yes, please list allergies. _____

25. Do you Smoke? Yes _____ (_____ packs/day) No _____

26. Do you drink Alcohol? Yes _____ (_____ Daily/ _____ Every Weekend/Occasionally) No _____

27. Do any specific medical conditions run in your family such as high Blood Pressure, Diabetes,
Heart Attack, Cancer, etc? Yes _____ No _____ If Yes, Please list _____

28. Please check all symptoms you are experiencing:

Constitutional:	_____ Night-time fevers/Chills
	_____ Severe Weight Loss/gain
	_____ Worse night-time pains
Eyes:	_____ Blurry vision
	_____ Pain
	_____ Infection

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Ears/Nose/Throat:	<input type="checkbox"/> Hearing Aid
	<input type="checkbox"/> Chronic sinus problems
	<input type="checkbox"/> Swallowing difficulty
	<input type="checkbox"/> Infection
Cardiovascular:	<input type="checkbox"/> Shortness of breath
	<input type="checkbox"/> Chest pain with activity or at rest
	<input type="checkbox"/> Awakened at night with shortness of breath
	<input type="checkbox"/> Sleep on 2 or more pillows at night
Respiratory:	<input type="checkbox"/> Shortness of breath
	<input type="checkbox"/> Wheezing
	<input type="checkbox"/> Coughing with production of sputum
Gastrointestinal:	<input type="checkbox"/> Abdominal pain/cramps
	<input type="checkbox"/> Nausea/Vomiting / Diarrhea
Genitourinary:	<input type="checkbox"/> Frequent Urinary Tract Infections
	<input type="checkbox"/> Urinate more frequently
	<input type="checkbox"/> Having trouble releasing urine or accidents on self
Musculoskeletal:	<input type="checkbox"/> Muscle Aches and Pains
	<input type="checkbox"/> Sever joint pain/stiffness
	<input type="checkbox"/> Weakness of an arm/leg
	<input type="checkbox"/> History of fractures
Integument:	<input type="checkbox"/> Skin infections
	<input type="checkbox"/> History of skin cancer
	<input type="checkbox"/> Any prior skin wound infections after surgery
Neurological:	<input type="checkbox"/> Numbness or Weakness of arm/leg
	<input type="checkbox"/> Burning pain running down arm/leg
	<input type="checkbox"/> Any trouble with normal balance
	<input type="checkbox"/> Any hand numbness that awakens you from sleep
	<input type="checkbox"/> Any noticeable clumsiness or dropping of objects
Psychiatric:	<input type="checkbox"/> History of depression
	<input type="checkbox"/> Inpatient/Outpatient Psychiatric treatment
	<input type="checkbox"/> History of hyperthyroidism
Hematologic:	<input type="checkbox"/> Treated for Anemia
	<input type="checkbox"/> History of Leukemia or Hodgkin's disease
	<input type="checkbox"/> History of free-bleeding with minor cut
Allergies:	<input type="checkbox"/> Food or Drug allergies
	<input type="checkbox"/> Seasonal sinus allergies
	<input type="checkbox"/> Severe allergic reaction to a Food or Drug

Patient Signature

Date