DISC AND SPINE ROBERT ROVNER, MD - VIKRAM TALWAR, MD- NEW PATIENT HEALTH QUESTIONNAIRE

Full Name:_____Date of Birth:_____

Date of Visit:_____

Height:_____ Weight:_____ Age:_____

TODAY'S VISIT

What is the reason for your visit today / chief complaint?

Was this MVA related? ☐Yes ☐ No **Work-related injury?** ☐Yes ☐ No **Date of onset:** _____

Do you need a work note or forms completed? ☐Yes ☐ No
Form/note type:

How often does the pain/numbness occur: ☐ Rare ☐ Intermittent ☐ Occasional ☐ Persistent ☐ N/A

What is the status of your condition since the onset date:
☐ Unchanged ☐Improving ☐Fluctuating ☐Stable ☐Worse ☐ Resolved

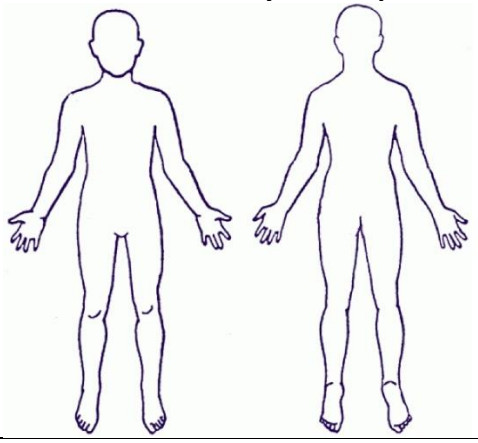
What is the severity of your pain / numbness? (circle a number)
No Pain -- 0 1 2 3 4 5 6 7 8 9 10 -- Incapacitating

Where type of pain/ numbness are you experiencing? Check all that apply ☐ No pain/numbness
☐ Ache ☐ Burning ☐ Deep ☐ Superficial ☐ Dull ☐ Localized ☐ Piercing
☐ Sharp ☐Shooting ☐ Throbbing ☐ Electric ☐ Tingling ☐ Numb ☐ Discomfort

What is the location of your pain/numbness? Check all that apply ☐ No pain/numbness

☐ Neck	☐ Upper back	☐ Mid back	☐ Lower back	☐ Gluteal area	☐ Flank
☐ Thighs	☐ Legs	☐ Shoulder	☐Arm	☐ Hand	☐ Fingers
☐ Other:_____	(circle one)	(circle one)	(circle one)	(circle one)	(circle one)
	RT / LT / Both	RT / LT / Both	RT / LT / Both	RT / LT / Both	RT / LT / Both

Below "X" the areas you feel pain



Circle which best describes your pain:

Full Name:_____Date of Birth:_____

What aggravates your condition? Check all that apply ☐ Nothing aggravates my condition
☐ Daily activity ☐ Ascending stairs ☐ Descending stairs ☐Coughing ☐ Driving
☐ Flexion ☐ Extension ☐ Lifting weight ☐ Rotating/twisting ☐ Bending ☐ Standing
☐ Sitting ☐ Walking ☐ Exercise ☐ Lying down/sleep ☐ Other:_____

What relieves your condition? Check all that apply ☐ Nothing relieves my condition
☐ Ice ☐ Heat ☐ Elevation ☐Mobility ☐ Rest ☐ Stretching ☐ Exercise ☐ Brace
☐ Massage ☐ Physical therapy (how many visits completed):_____ ☐ Acupuncture ☐ Chiropractic
☐ Injection ☐ OTC meds (which med):_____
☐ Pain medication (which med):_____
Pain level after taking your medication: No Pain - 0 1 2 3 4 5 6 7 8 9 10 - Incapacitating

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING (including OTC/vitamins/herbals/supplements)

☐ **No medications to list**
☐ **See attached medications list**
Are you taking blood thinners? ☐ Yes ☐ No

Medication	Dosage & Frequency	Purpose & Administered route i.e. oral/IV/topical	Physician

DRUG & OTHER ALLERGIES (list):

☐ **NO KNOWN DRUG ALLERGIES**

Have you had a fall in the last 12 months? ☐Yes ☐ No **More than 2 times?** ☐Yes ☐ No

SOCIAL HISTORY

Occupation:_____ Employer:_____Still employed?☐Yes ☐ No
Marital status:_____Do you exercise?☐Yes☐ No If yes, how often?:_____
Do you smoke tobacco products? ☐Yes ☐ No If yes, have you ever tried to quit? ☐Yes ☐ No
Type:_____ Packs per day:_____ Years used:_____
Do you drink alcohol? ☐Yes☐ No If yes, how many drinks per week?_____
Have you traveled or lived outside the US or Canada? ☐Yes☐ No If yes, when/where:_____

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PAST MEDICAL AND FAMILY HISTORY			
Illness/Condition	**Self**	**Relative**	**Describe**
Anesthesia complications	☐Yes ☐ No	☐Yes ☐ No	
Bleeding prob/blood clots	☐Yes ☐ No	☐Yes ☐ No	
Cancer	☐Yes ☐ No	☐Yes ☐ No	
Diabetes	☐Yes ☐ No	☐Yes ☐ No	
Heart disease	☐Yes ☐ No	☐Yes ☐ No	
Hepatitis/HIV	☐Yes ☐ No	☐Yes ☐ No	
Liver disease	☐Yes ☐ No	☐Yes ☐ No	
Psychiatric illness	☐Yes ☐ No	☐Yes ☐ No	
Stroke/TIA	☐Yes ☐ No	☐Yes ☐ No	
Tuberculosis	☐Yes ☐ No	☐Yes ☐ No	
Other:	☐Yes ☐ No	☐Yes ☐ No	

DIAGNOSTIC HISTORY			☐ None
Study	**Within 6 months**	**Within 1 year**	**Body Part**
X-rays	☐Yes ☐ No	☐Yes ☐ No	
MRI/CT	☐Yes ☐ No	☐Yes ☐ No	
EMG/nerve conduction studies	☐Yes ☐ No	☐Yes ☐ No	
Myelogram	☐Yes ☐ No	☐Yes ☐ No	
Bone scan/DEXAscan	☐Yes ☐ No	☐Yes ☐ No	
Other:	☐Yes ☐ No	☐Yes ☐ No	

PAST TREATMENTS RELATING TO CURRENT PROBLEM(S)					☐ None
Treatment	**Within 6 mo.**	**Within 1 yr.**	**# of**	**Provider**	**% of relief**
Activity modification	☐Yes ☐ No	☐Yes ☐ No			
Bracing	☐Yes ☐ No	☐Yes ☐ No			
Injection/nerve block	☐Yes ☐ No	☐Yes ☐ No			
Drug/medications	☐Yes ☐ No	☐Yes ☐ No			
Physical therapy	☐Yes ☐ No	☐Yes ☐ No			
Chiropractic	☐Yes ☐ No	☐Yes ☐ No			
Acupuncture	☐Yes ☐ No	☐Yes ☐ No			
Home exercise	☐Yes ☐ No	☐Yes ☐ No			

PRIOR SURGERY				☐ None
Name of Operation	**Reason**	**Date**	**Facility**	**Physician**

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REVIEW OF SYSTEMS

CHECK IF YOU HAVE ANY OF THE FOLLOWING

Constitutional
- ☐ Fever/chills/night sweats
- ☐ Weakness/fatigue
- ☐ Weight gain
- ☐ Weight loss
- ☐ Other:_____

Cardiovascular
- ☐ Stroke/blood clots
- ☐ Chest pain
- ☐ Abnormal heart rhythm
- ☐ High blood pressure
- ☐ Heart problem:_____
- ☐ Other:_____

Integumentary
- ☐ Rash
- ☐ Skin infections
- ☐ Skin lesions
- ☐ Other: _____

Ear, Nose, Throat & Eyes
- ☐ Eye/vision disorders
- ☐ Frequent sore throat
- ☐ Vertigo/dizziness
- ☐ Voice hoarseness
- ☐ Difficulty swallowing
- ☐ Other: _____

Gastrointestinal (GI)
- ☐ Constipation/diarrhea
- ☐ Liver/gallbladder issues
- ☐ Nausea/vomiting
- ☐ Ulcers
- ☐ Heartburn/reflux
- ☐ Black or bloody stool
- ☐ Other: _____

Neurological
- ☐ Diff. walking/balance
- ☐ Dizziness
- ☐ Seizures
- ☐ Headache
- ☐ Weakness/numbness
- ☐ Neurologic problem
- ☐ Other: _____

Respiratory
- ☐ Lung issues:_____
- ☐ Recent cold/flu
- ☐ Wheezing/asthma
- ☐ Coughing blood
- ☐ Shortness of breath
- ☐ Abnormal chest x-ray
- ☐ Other: _____

Genitourinary
- ☐ Kidney stones
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Kidney disease
- ☐ Bladder leakage
- ☐ Other: _____

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Mood disorder
- ☐ Other:_____

Allergic/Immunologic
- ☐ Rheumatoid arthritis
- ☐ Lupus
- ☐ Hives/Eczema
- ☐ Autoimmune disorder
- ☐ Other:_____

Musculoskeletal
- ☐ Arthritis/osteoporosis
- ☐ Broken bones
- ☐ Joint pain/swelling
- ☐ Carpal tunnel
- ☐ Other:_____

Endocrine
- ☐ Diabetes – I or II
- ☐ Parathyroid/Paget's
- ☐ Heat/cold intolerance
- ☐ Thyroid disorder
- ☐ Other:_____

Hematology/Lymphatic
- ☐ Easy bruising/bleeding
- ☐ Enlarged glands
- ☐ Anemia
- ☐ Blood transfusions
- ☐ Other:_____

Females Only
- ☐ Pregnant
- ☐ Last menstrual period: _____

Other:

☐ **ALL NEGATIVE**

Office use:

Pulse:_____ BP:_____ BMI:_____

_____ _____

Patient Signature **(Date)** **Provider Signature** **(Date)**