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

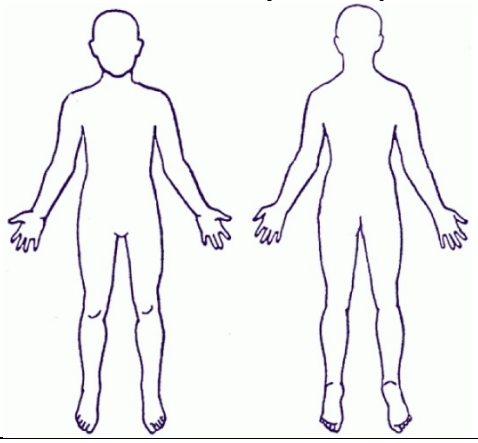
**What is the severity of your pain / numbness?** (circle a number)
**No Pain -- 0 1 2 3 4 5 6 7 8 9 10 -- Incapacitating**

**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) RT / LT / Both | (circle one) RT / LT / Both | (circle one) RT / LT / Both | (circle one) RT / LT / Both | (circle one) RT / LT / Both |

**Below "X" the areas you feel pain**



**Circle which best describes your pain:**

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**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**

**Anything else you would like addressed in your appointment today:**

**PLEASE LIST ALL MEDICATIONS YOU ARE TAKING (including OTC)**

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

| Medication Name | Dose | Purpose | 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** | **Date** | **Results** |
| **X-rays** | | |
| **MRI/CT** | | |
| **EMG/nerve conduction studies** | | |
| **Myelogram** | | |
| **Bone scan/DEXAscan** | | |
| **Other:** | | |

| PAST TREATMENTS RELATING TO CURRENT PROBLEM(S) ☐ None | | | | |
|---|---|---|---|---|
| **Treatment** | **Start Date** | **End Date** | **Provider** | **% of relief 0-100** |
| **Activity modification** | | | | |
| **Bracing** | | | | |
| **Injection/nerve block** | | | | |
| **Drug/medications** | | | | |
| **Physical therapy** | | | | |
| **Chiropractic** | | | | |
| **Acupuncture** | | | | |
| **Home exercise** | | | | |
| **Other:** | | | | |

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

Full Name:_____Date of Birth:_____

## REVIEW OF SYSTEMS

**CHECK IF YOU HAVE ANY OF THE FOLLOWING** ☐ **ALL NEGATIVE BELOW**

**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:**

***FOR STAFF USE ONLY:*** Pulse:_____ BP:_____ BMI:_____

Oriented x 3: ☐ Awake ☐ Responsive ☐ Oriented to person/place/time

_____ _____

Patient Signature (Date) MD/ PA Signature (Date)