DISC AND SPINE ROBERT ROVNER, MD–VIKRAM TALWAR, MD -Follow Up 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?
Do you need a prescription or refill? ☐Yes ☐ No Which medication:
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

What type of pain/ numbness are you experiencing? Check all that apply ☐ No pain/numbness

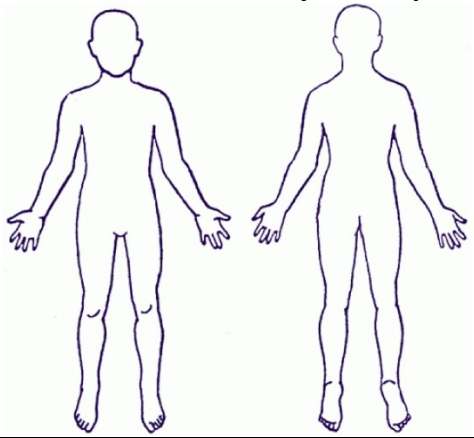
☐ Ache ☐ Burning ☐ Deep ☐ Superficial ☐ Dull ☐ Localized ☐ Piercing

☐ Sharp ☐ Shooting ☐ Throbbing ☐ Electric ☐ Tingling ☐ Numb ☐ Discomfort

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

☐ Neck	☐ Upper back	☐ Mid back	☐ Lower back	☐ Gluteal area	☐ Right 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:

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:_____

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What relieves your condition? Check all that apply ☐ Nothing relieves my condition

☐ Ice ☐ Heat ☐ Elevation ☐Mobility ☐ Rest ☐ Stretching ☐ Exercise ☐ Brace

☐ Massage ☐ Acupuncture ☐ Physical therapy (how many visits completed): _____

☐ Chiropractic ☐ Injection ☐ OTC meds (which med):_____

☐ Pain medication (which med):_____

Pain level after taking your medication:(circle) **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 NEW MEDICATIONS YOU ARE TAKING SINCE YOUR LAST VISIT (including OTC)

List NEW allergies:_____ ☐ **No NEW allergies**

☐ **No new medications to list**

Are you taking blood thinners? ☐ Yes ☐ No

Medication Name	Dose	Medication Name	Dose

Any additional new medical history information:

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

SOCIAL HISTORY ☐ **No changes**

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:_____

DIAGNOSTIC HISTORY SINCE LAST VISIT ☐ **No changes**

Study	Date	Results
X-Rays		
MRI/CT		
EMG/nerve conduction studies		
Myelogram		
Bone scan/DEXAscan		

TREATMENTS SINCE LAST VISIT ☐ **No changes**

Treatment	Start Date	End Date	Provider	% of relief 0-100
Activity modification				
Bracing				
Injection/nerve block				
New drugs/medications				
Physical therapy				
Chiropractic				

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Acupuncture				
Home exercise				
Other:				

Have you had any surgeries since your last visit? ☐Yes ☐ No **If yes, please describe:**

REVIEW OF SYSTEMS ☐ **No changes**

CHECK IF YOU HAVE ANY NEW ISSUES

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 of person/place/time

_____ _____

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