MR # _____

CENTRAL FLORIDA
SPINE INSTITUTE
Minimally Invasive Spine Surgery

## 2022 FIRST VISIT QUESTIONNAIRE

Central Florida Spine Institute is a spine only specialist office, therefore due to insurance purposes we will focus on one part of the spine at each visit. If you have any questions, please ask for assistance.

**Name:** _____ **DOB:** _____ **Date of Visit:** _____

**Sex:** **Male** **Female**

**Referred By:** _____ **Is this a second opinion?** **YES** **NO**

**Primary Care Physician:** _____

**Pharmacy Preference:** _____

**Please choose areas that are affecting and circle all that apply:**

A. **Neck Area: headaches, arm pain, arm numbness, shoulder pain, right side, left side, both**
B. **Upper back: thoracic pain, rib area pain, right side, left side, both**
C. **Lower back: buttock pain, thigh pain, leg pain, leg numbness, hip pain, pain in feet, pain in toes, right side, left side, both**

**Is the condition you are being seen for a result of a motor vehicle accident / slip and fall / or a work related injury? Please indicate.**

A. **Yes, please list date of accident:** _____
B. **No**

**Has an attorney or adjuster been retained? Please indicate.**

A. **Yes, Adjustors or attorneys name/phone number**
B. **No**

**IF pain is due to an accident, please describe circumstances regarding accident below.**

_____

_____

_____

_____

_____

_____

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**TREATMENT HISTORY for CURRENT SPINE CONDITION (HPI)**

**(Please circle all that apply)**

**What type of treatment have you tried currently or in the past to relieve your symptoms for the specific area we are evaluating today?**

- **Prescribed physical therapy: NO YES Currently Receiving within Past year**

**If Yes, where: _____**

**Did physical therapy relieve your symptoms? No help Helped a little Temporarily Relief Helped significantly**

- **Spinal Epidural Injections: NO YES Currently Receiving within Past year**

**How many injections have you had in the last 12 months? _____**

**Physician whom performed your injections? _____**

**Did the injections relieve your symptoms? No help Helped a little Helped temporarily Helped significantly**

- **Have you had any recent radiological diagnostic studies for the spine condition that we are seeing you for today?**

| Please check any/all that apply. | | Where and when performed? |
|---|---|---|
| **CERVICAL** _____ | **CT** _____ | _____ |
| **LUMBAR** _____ | **MRI** _____ | _____ |
| **THORACIC** _____ | **X-RAYS** _____ | _____ |

**ALLERGIES**

**Do you have any known drug or other allergies (including iodine/contrast dye or shellfish)?**

**PLEASE CIRCLE ONE:**

A. **NO known drug allergies**
B. **YES, Please list**

| Allergy | Reaction |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

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## CURRENT MEDICATIONS

**Are you currently taking ANY medications (prescribed or over the counter)? If you have a prepared list, please mark see attached.**

- **A. None**
- **B. Yes** **See Below** **See Attached List**

| Name | Dose | Reason for Taking |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## FAMILY HISTORY

**Has mother, father, brother, sister been diagnosed with the following condition(s)?**

| | | |
|---|---|---|
| Arthritis | Heart Disease | Scoliosis |
| Cancer/Malignant neoplastic disease | Hypertension/High Blood Pressure | Stroke |
| Diabetes | Musculoskeletal Disease | Other:_____ |
| Disorder of the Back | Osteoarthritis | _____ |
| Disorder of the Neck | Osteoporosis | _____ |
| Heart Attack – Cardiovascular Incident | Rheumatoid Arthritis | |

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## SOCIAL HISTORY

**Do you currently smoke?** **NO** **YES: Packs Per day_____** **Number of Years: _____**

**Tobacco Use?** **NO** **YES: Amount per day_____**

**Did you ever smoke regularly before?** **NO** **YES: Packs Per day_____** **Number of Years: _____**

**How many years did you smoke? _____** **When did you quit smoking? _____**

**Education: ___Did not complete high school** **___High School** **___ College** **___ Graduate school**

**Occupation: _____**

**Marital Status: ___Single** **___ Married** **___ Divorced** **___ Widowed**

**Live:** **___ Alone** **___ With others**

**Home:** **___ Single level** **___ Multi level**

**Alcohol Consumption (per week): NONE** **< 6 drinks** **6-12 drinks** **12-24 drinks** **24-48 drinks** **48 drinks or over**

**Illicit Drugs:** **NO** **YES: Specify: _____**

**Exercise Level:** **___ None** **____ 2 x a week** **___5 x a week** **____ Everyday**

**Sporting Activities: Please list.**

**_____**

**Advanced Directive:** **NO** **YES**

**Are you currently Employed?** **NO** **YES, Employer: _____**

**What is your current work status? (please circle and specify if needed)**

**Full time with / without restrictions**

**Part time with / without restrictions**

**Retired by choice**

**Unemployed**

**Student**

**Other: _____**

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## SURGICAL HISTORY

**Have you had Spine Surgery in the past? Neck or Back, please specify.**

- **A. NO**
- **B. YES, Please list below**

| Date | Procedure & Levels | Surgeon Name |
|---|---|---|
| _____ | _____ | |
| _____ | _____ | |
| _____ | _____ | |
| _____ | _____ | |

**Have you had any other surgical procedures (other than the spine)?**

- **A. NO**
- **B. YES, Please list below**

| Date | Procedure | Surgeon Name |
|---|---|---|
| _____ | _____ | |
| _____ | _____ | |
| _____ | _____ | |
| _____ | _____ | |

## PAST MEDICAL HISTORY

| | | |
|---|---|---|
| Anemia | Heart Disease | Osteoporosis |
| Arthritis | Heart problems | Pacemaker |
| Asthma | Hepatitis: Type _____ | Pulmonary embolism |
| Bleeding disorder | High blood pressure | Peripheral vascular disease |
| Blood clots | High cholesterol | Rheumatoid arthritis |
| Cancer: Type _____ | Immune disorder | Seizures/epilepsy |
| Circulation problems | Kidney disease | Stroke: When _____ |
| Coronary artery disease | Leg or foot ulcers | Tuberculosis |
| Depression | Liver disease | Ulcers |
| Diabetes: Type _____ | Mental Disorder: _____ | UTI |
| HIV/AIDS | Migraines | Other: _____ |
| Heart attack: When _____ | Osteoarthritis | _____ |

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**REVIEW OF SYSTEMS**

**Have you recently experienced any of the following? Please circle all that apply.**

| | |
|---|---|
| **Constitutional:** | Fever Night sweats Weight Gain Weight Loss |
| **Eyes:** | Dry Eyes Irritation Vision Changes |
| **ENMT:** | |
| **Ears:** | Difficulty Hearing |
| **Nose:** | Frequent nose bleeds Nose or sinus problems |
| **Mouth/Throat:** | Sore throat Bleeding gums Snoring Dry Mouth Oral Abnormalities Mouth Ulcers Teeth Abnormalities Mouth Breathing |
| **Cardiovascular:** | Chest Pain on Exertion Arm Pain on Exertion Shortness of Breath when walking Shortness of Breath when lying down Palpitation Known Heart Murmur Lightheaded on standing |
| **Respiratory:** | Cough Wheezing Shortness of Breath Coughing up Blood Sleep Apnea |
| **Gastrointestinal:** | Abdominal Pain Vomiting Change in Appetite Black tarry stools Frequent diarrhea Vomiting Blood |
| **Genitourinary:** | Urinary loss of control Difficulty urinating Increased urinary frequency Hematuria Incomplete Emptying |
| **Musculoskeletal:** | Muscle aches Muscle weakness Back Pain Arthralgia/joint pain Swelling in extremities |
| **Integumentary:** | Abnormal mole Jaundice Rash Itching Dry skin Growth/lesions |
| **Neurologic:** | Loss of consciousness Weakness Numbness Dizziness Seizures Frequent headaches/migraines Restless legs |

**Have you had any problems bowel, bladder or sexual functions since this condition began?**

**NO YES, Please explain**

**_____**

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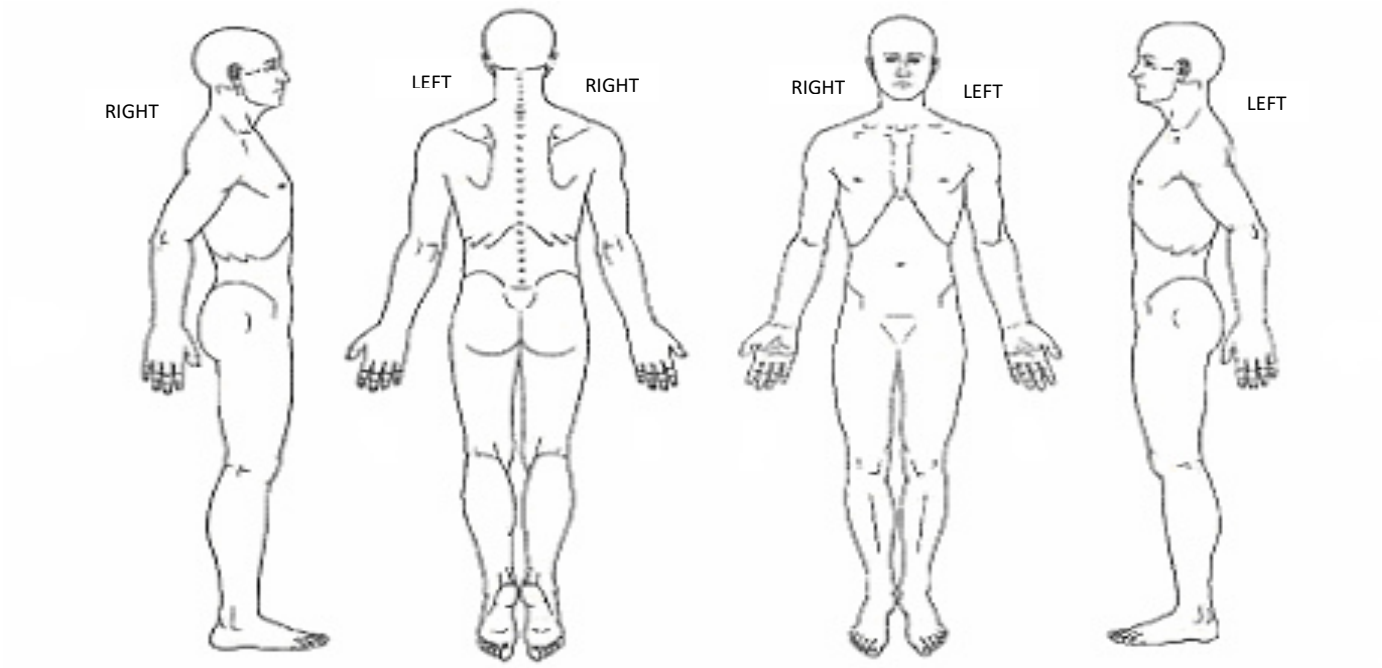
**PAIN DIAGRAM**

**Please indicate where your pain is on your body.**

**Draw XXXX for areas of pain**

**Draw OOOO for areas of numbness and/or tingling**




**0 1 | 2 3 | 4 5 6 | 7 8 | 9 10**

**No Pain Mild Pain Moderate Pain Severe Pain Extreme Pain**

**On a scale of 1 to 10, please indicate what you would consider your daily pain level to be _____**

**On a scale of 1 to 10, please indicate what you would consider your highest pain level has reached _____**

**Signature: X_____**

**Medical Assistant: _____**