Erik C. Spayde, M.D.

Please fill out this form in its entirety and fill in the bubbles completely.

PATIENT INFORMATION

Patient Name:		**Date:**
Date of Birth:	**Height:**	**Weight**
Referring Physician:	**Primary Care Physician:**	

I. What are you being seen for today? O Neck O Back O Other _____

II. Which side is affected? O Right O Left O Bilateral

Are you? O Left handed O Right handed

III. Date of Injury or start of pain: _____

How did the pain occur? O Injury O Chronic O Spontaneous

Is this work related? O Yes O No

Is this the result of a motor vehicle accident? O Yes O No

IV. Pain Description

Quality of your pain? O Mild O Moderate O Severe

Type of pain? O Sharp O Dull O Other:_____

V. Pain Calculation: Questions A and B should total 100%

A. What percentage of your problem is due to back/neck pain?

O 0% O 25% O 50% O 75% O 100%

B. What percentage of your problem is due to leg/arm pain?

O 0% O 25% O 50% O 75% O 100%

VI. General Questions

How would you rate your pain? Place a vertical mark on the line below:

No pain 0|_____|10 very severe pain

Have you had any change in bowel or bladder function? O Yes O No

Does your pain disrupt your sleep? O Yes O No

Does pain or weakness keep you from doing your regular activities? O Yes O No

Have you had physical therapy? O Yes O No

Does your pain radiate? O Yes O No If so, where _____

VII. Pain medications?

Anti-inflammatory agent O Yes O No Drug Name:_____

Pain Medication O Yes O No Drug Name:_____

Tylenol O Yes O No

Have you had any injections/epidurals? O Yes O No

How many in the last 12 months? _____ Date of most recent injection: _____

Did you get any relief? O Yes O No

If yes, for how long? _____

VIII. Have you had any testing? O MRI O EMG/NCS O X-ray O CT Scan

Medical History

Do you have or have you had:	Yes	No		Yes	No
Asthma/COPD	O	O	Cancer	O	O
Diabetes	O	O	High Blood Pressure	O	O
Acid Reflux Disease	O	O	Heart Attack	O	O
Osteoporosis	O	O	Hypertension	O	O
Emphysema	O	O	Seizures	O	O
Stroke	O	O	Arthritis	O	O
Gout	O	O	Thyroid Disease	O	O
Kidney Problems	O	O	Blood Clots	O	O

Social History

Marital status: O Single O Married O Widowed O Divorced

Do you smoke? O Yes O No O Have Previously

If yes,

How many packs/ day? O <1 O 1-2 O >2

How many years have you smoked? O 1-4 O 5-10 O >11

Do you consume alcohol? O Yes O No

In the past did you consume alcohol? O Yes O No

How often do you consume alcohol? O Daily O Social O Never

Do you exercise regularly? O Yes O No

Working status: O Full time O Part Time O Student O Unemployed

Family History

Father	O	Arthritis	O	Cancer	O	Diabetes	O	Stroke	O	Heart Trouble	O Lung Disease
Mother	O	Arthritis	O	Cancer	O	Diabetes	O	Stroke	O	Heart Trouble	O Lung Disease
Siblings	O	Arthritis	O	Cancer	O	Diabetes	O	Stroke	O	Heart Trouble	O Lung Disease
Grandparents	O	Arthritis	O	Cancer	O	Diabetes	O	Stroke	O	Heart Trouble	O Lung Disease

Review of Systems

Constitutional

Fatigue	O	Yes	O	No
Weight change	O	Yes	O	No
Fever	O	Yes	O	No

Neurological

Migraine Headaches	O	Yes	O	No
Numbness/ Tingling	O	Yes	O	No
Seizures	O	Yes	O	No
Dizziness	O	Yes	O	No
Coordination Problems	O	Yes	O	No
Neck Pain	O	Yes	O	No

Respiratory

Shortness of Breath	O	Yes	O	No
Chest Pain	O	Yes	O	No
Trouble Breathing	O	Yes	O	No
Wheezing/ Asthma	O	Yes	O	No
Chronic Coughing	O	Yes	O	No
Coughing up Blood	O	Yes	O	No

Cardiovascular

Chest Pain	O	Yes	O	No
Irregular Heartbeat	O	Yes	O	No
High Blood Pressure	O	Yes	O	No
Leg/Ankle swelling	O	Yes	O	No

Spine

Severe Back Pain	O	Yes	O	No
Spine Curvature	O	Yes	O	No
Back Problems	O	Yes	O	No

Musculoskeletal

Joint pain	O	Yes	O	No
Joint stiffness	O	Yes	O	No
Joint swelling	O	Yes	O	No

Gastrointestinal

Nausea/ Vomiting	O	Yes	O	No
Stomach Ulcer	O	Yes	O	No
Diarrhea	O	Yes	O	No
Blood in stool	O	Yes	O	No

Skin

Rashes/sores	O	Yes	O	No
Skin Cancer	O	Yes	O	No
Itching/ Burning	O	Yes	O	No

Hematologic

Anemia	O	Yes	O	No
Easy Bruising	O	Yes	O	No
Bleeding problem	O	Yes	O	No

Women ONLY:

Are you pregnant or could possibly by pregnant?

O Yes O No

Allergies

Are you allergic to any medications? O Yes O No

If yes, please list: _____

Are you allergic to food or environmental substances? O Yes O No

If yes, please list: _____

Medications (Please list name of medication and dosage)	

Hospitalization (Please list)	Surgeries (Please list surgery type and year)

Patient Signature _____ Date _____