Newton Wellesley Interventional Spine

Questionnaire

Name: _____

Date of Appointment:____/___/____

How were you referred to Newton Wellesley Interventional Spine?

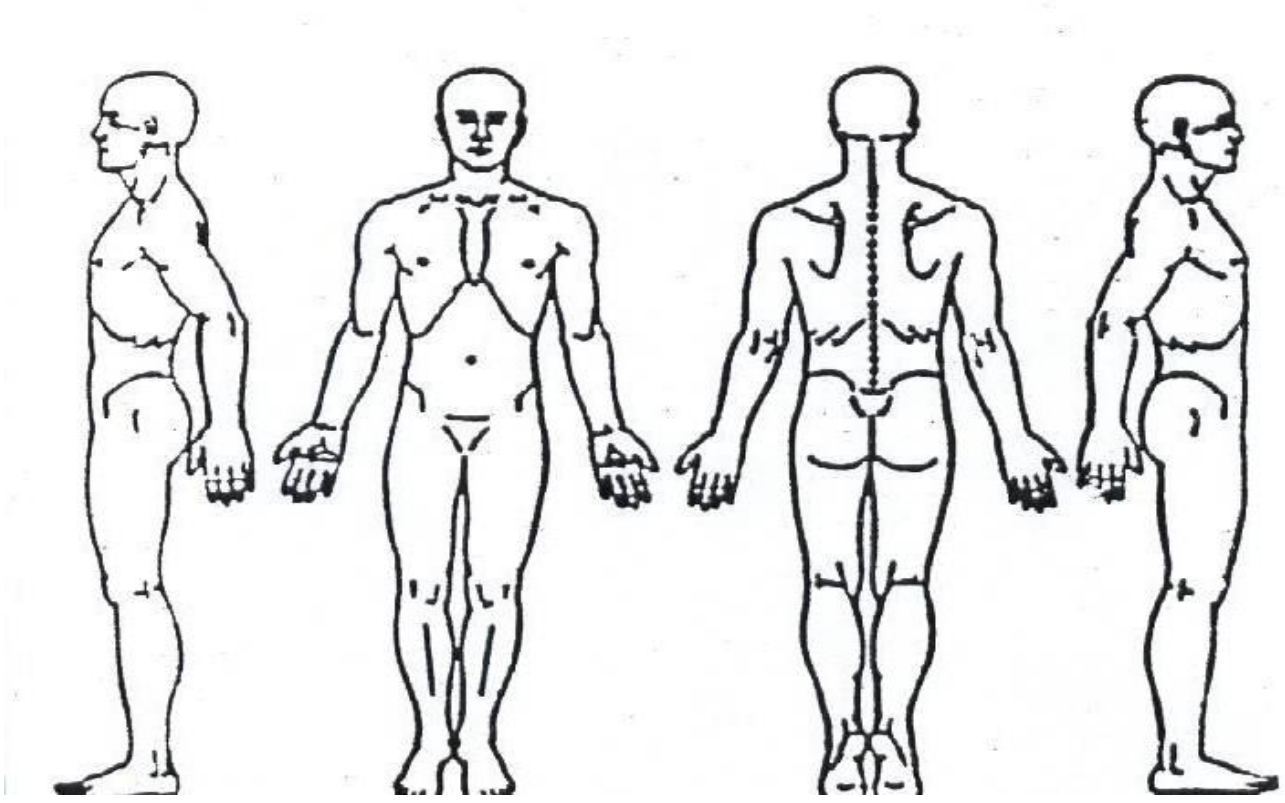
- ☐ Physician:_____
- ☐ Other: _____

Reason for the visit?

☐ Lower Back Pain Hip/Leg Pain ☐ Right ☐ Left ☐ Both

☐ Neck Pain Shoulder/Arm Pain ☐ Right ☐ Left ☐ Weakness

☐ Mid Back Pain ☐ Weakness



PAIN LINE Indicate your usual level of pain (0-10)

No pain (0/10) **Severe pain (10/10)**

Have you had a previous history of these symptoms or is this a new problem?

☐ Previous History ☐ New Problem

How would you describe your pain?

☐ Deep ☐ Electrical ☐ Sharp ☐ Stabbing ☐ Dull ☐ Burn ☐ Ache ☐ Other

☐ Constant ☐ Intermittent

What position makes the pain worse?_____

What position makes the pain better?_____

Is your condition caused by an Injury: ☐ Yes Injury date/type:_____ ☐ No

How quickly did the pain start following the injury if any?

____Minutes ____Hours ___Days __Weeks_____Months___Years

If you had symptoms prior to the injury, are your current symptoms

☐ Better ☐ Worse ☐ Come and go

Please indicate if you have received any of the following treatments for your pain condition, when the treatment occurred, and whether the outcome was positive (+) or negative (-)		
Treatment	**Approximate Month & Year**	**Result (+ or -)**
Surgery		
Physical Therapy		
Chiropractic Treatment		
Injections in the Office		
Injections Guided by X-Ray		

Have you had any Spine diagnostic imaging (MRI, CT, x-rays, bone scan) within the past 6 months, if so, at what facility? _____

What Medications are you <u>CURRENTLY</u> taking? (Enclose a separate a list if needed)

Surgical History – Please list any previous surgeries and their respective dates

Date	Surgery

Are you allergic to any of the following? (Describe type of reaction)

a. Shellfish Yes ☐ No ☐ _____

b. Contrast Dye Yes ☐ No ☐ _____

c. Local anesthetic Yes ☐ No ☐ _____

d. Medications Yes ☐ No ☐ _____

If 'Yes,' indicate which medications:

Do you have a Kidney Disease?

Yes ☐
No ☐

Do you have a bleeding problem or <u>use blood thinner</u> ?

Yes ☐
No ☐

Medical History - Check (√) any of the following conditions if applicable

○ High Blood Pressure ○ Heart Disease ○ Arrythmia ○ Thyroid ○ Asthma/COPD ○ Gastritis/Ulcer	○ Kidney Disease ○ Liver Disease ○ Bleeding Disorder ○ Migraine Headaches	○ Seizure Disorder ○ Cancer • Type_____ • Management _____ _____ _____	○ Vascular Disease ○ Diabetes ○ Cataract ○ Glaucoma

Family History:

_____

_____

Please check the box if you are experiencing any of the following symptoms

CONSTITUTIONAL	CARDIOVASCULAR	GASTROINTESTINAL
❑ Weight gain	❑ Chest pain / pressure/ tightness	❑ Persistent/recurring stomach pain
❑ Weight loss	❑ Palpitations	❑ Loss of bowel control
❑ F atigue/weakness	❑ Rapid heart rate	❑ Diarrhea
❑ Fever	❑ Low blood pressure	❑ Constipation
❑ Night sweats	❑ High blood pressure	❑ Blood in stool
❑ Heat/Cold intolerance	❑ Shortness of breath	❑ Heartburn or indigestion
❑ Depression or other emotional changes	❑ Poor circulation	❑ Nausea/vomiting
MUSCULOSKELETAL	**NEUROLOGICAL**	**RESPIRATORY**
❑ Joint pain	❑ Headaches	❑ Persistent cough
❑ Joint stiffness	❑ Blackouts/Fainting	❑ Coughing up blood
❑ Joint redness or swelling	❑ Seizures	❑ Wheezing
❑ Cramps	❑ Memory loss	
EARS, NOSE & THROAT	**SKIN**	**EYES**
❑ Loss of hearing	❑ Frequent bruising	❑ Blurred vision
❑ Vertigo/Dizziness	❑ Rash	❑ Double vision
❑ Ringing in ears	❑ Nail or hair changes	❑ Eye pain
❑ Sinus problems	❑ Skin ulceration	
GENITOURINARY	**MEN ONLY**	**WOMEN ONLY**
❑ Blood in urine	❑ Breast lump	❑ Unusual menstrual pain
❑ Painful or difficulty urination	❑ Penis discharge	❑ Painful intercourse
❑ Urgency to urinate	❑ Sore on penis	❑ Breast pain
❑ Loss of bladder control	❑ Lump on testicle	❑ Date of last mammogram if applicable_____
❑ Frequent urination		

Social / Vocational / Work History

Do you smoke cigarettes? ☐ Yes ☐ No

Do you have a history of alcohol or drug abuse? ☐ Yes ☐ No

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employment Status ☐ Unemployed ☐ Employed ___Full Time ____Part Time

If unemployed right now, indicate the last date worked:_____/_____/_____

If out of work, is it because of this spine condition? ☐ Yes ☐ No

Functional History

Exercise_____

Work Activity_____

Assistive Device in Ambulation_____

Assistance in Activity of Daily Living _____

Patient Name_____Signature_____Date ___/___/____

Reviewed by_____Date____/___/____