Neurosurgery New Patient Questionnaire

Lifespan Physician Group, Inc.
Neurosurgery
Delivering health with care.®

Demographics

Name: _____ DOB: _____ Age: _____
Social Security #: _____ Address: _____
City: _____ State: _____ Zip: _____ Home Phone: _____
Cell Phone: _____ Email: _____

Emergency Contact: _____ Relationship to Insured: _____
Phone Number: _____

Insurance Type: _____ Insurance Company Name: _____
Insurance ID #: _____

Employment Status (Circle one): Full Time Part Time Disabled Retired Unemployed

Care Information

Pharmacy: _____ Address: _____
City: _____ State: _____ Zip: _____ Phone: _____

Referring Physician (if different from PCP): _____
Specialty: _____ Address: _____
City: _____ State: _____ Zip: _____

Primary Care Physician (PCP): _____
Address: _____ City: _____
State: _____ Zip: _____

Other Physician (if requesting report): _____
Address: _____ City: _____
State: _____ Zip: _____

Present Illness

1. What is the reason for your visit today? _____
2. What symptoms are you currently experiencing? _____

_____

3. How long have you had these symptoms? _____
4. How often do the symptoms occur? _____
5. How severe are the symptoms on a scale of 0 (no pain) to 10 (worst imaginable)?
0 1 2 3 4 5 6 7 8 9 1 0
6. Does anything make the problem better? Yes No Explain _____

_____

7. Does anything make the problem worse? Yes No Explain _____

_____

8. Have you had previous treatment for the problem? Yes (please circle below) No
PT Injections Pain Management Chiropractic Acupuncture Previous Surgery
other _____
9. Is this a Worker's Compensation Case? Yes No Case/insurance info: _____

_____

10. Is this a result of a Motor Vehicle Accident? Yes No Case/Insurance info: _____

_____

11. Is this a Medical Malpractice case? Yes No Case/Insurance info: _____

_____

Review of Systems

Please carefully circle each medical condition that currently applies to you.

CONSTITUTION
Activity change
Appetite change
Chills
Diaphoresis (sweating)
Fatigue (tiredness)
Fever
Unexpected weight loss
Unexpected weight gain

HEAD-EARS-NOSE-THROAT
Facial swelling
Neck pain
Neck stiffness
Ear discharge
Hearing loss
Ear pain
Tinnitus (ringing in ears)
Nosebleeds
Congestion
Rhinorrhea (runny nose)
Sneezing
Drooling
Mouth sores
Sore throat
Trouble swallowing
Voice change

EYES
Eye discharge
Eye itching
Eye pain
Photophobia (discomfort with light)
Visual disturbance

RESPIRATORY
Apnea
Chest tightness
Choking
Cough
Shortness of breath
Stridor (abnormal breathing sounds)
Wheezing

CARDIOVASCULAR
Chest pain
Leg swelling
Palpitations (racing heart beat)

GASTROINTESTINAL
Abdominal swelling
Abdominal pain
Anal bleeding
Blood in stool
Constipation
Diarrhea
Fecal incontinence (bowel accidents)
Nausea
Rectal pain
Vomiting

ENDOCRINE
Cold intolerance
Heat intolerance
Polydipsia (excessive thirst)
Polyphagia (excessive hunger)
Polyuria (excessive urine)

GENITOURINARY
Difficulty urinating
Dysuria (painful urination)
Enuresis (bed wetting)
Flank pain (side, back, or kidney)
Frequent urination
Genital sore (private area)
Hematuria (blood in urine)
Penile discharge
Penile pain
Penile swelling
Scrotal swelling
Testicular pain
Oligouria (urine decreased)
Urinary incontinence (accidents)

MUSCULAR
Arthralgias (joint pain)
Back pain
Gait problem (difficulty walking)
Joint swelling
Myalgia (muscle pain)

SKIN
Color change
Pallor (paleness)
Rash
Wounds

ALLERGIES AND IMMUNOLOGY
Environmental allergies
Food allergies
Immunocompromised (poor immune system)
Vomiting

NEUROLOGICAL
Dizziness
Facial asymmetry (face droop)
Headaches
Light-headedness
Numbness
Seizures
Speech difficulty
Syncope (fainting)
Tingling
Tremors (shakiness)
Weakness

HEMATOLOGIC
Enlarged lymph nodes
Bruises/bleeds easily

PSYCHIATRIC
Agitation
Confusion
Decreased concentration
Depressed
Hallucinations/ Delusions
Nervous/anxious
Self-injury
Sleep disturbance
Suicidal ideas

Past Medical History

Please carefully circle the medical problem or major illness you have or have had.
Please include approximate dates.

Medical Problem	Date	Medical Problem	Date
ADD/ADHD		Hyper/Hypothyroidism	
Alzheimer's disease		Intracranial aneurysm	
Anemia		Irritable bowel syndrome	
Anxiety		Kidney stones	
Arrhythmia/A-fib		Lower extremity edema	
Arthritis		Lyme disease	
Asthma		Migraine/Headaches	
Back pain		Mitral/ Aortic valve disease	
Bleeding Disorder		Multiple sclerosis	
Cancer (Type:_____)		Myocardial Infarction (heart attack)	
Cartoid Stenosis		Myopathy (muscular diesease)	
Carpal Tunnel		Neck pain	
Congestive heart failure		Neuropathy (nerve damage)	
Chiari malformation		Osteoporosis (bone disease)	
Kidney disease		Parkinson's (movement disorder)	
Chronic pain		Peptic ulcer disease	
COPD (lung disease)		Pneumonia	
Coronary artery diesase		Pseudomeningocele (CSF leak)	
Depression		Pseudotumor cerebri (false brain tumor)	
Diabetes		Scoliosis (curvature of the spine)	
Diverticulosis		Spine disorder	
DVT/Pulm. Embolism		Spine tumor	
Epilepsy/Seizures		Self-catheterization (urinary)	
Gastritis (stomach inflamation)		Shunt infection/Malfunction	
GERD (acid reflux)		Sinus thrombosis	
Glaucoma		Sleep apnea	
Hearing loss		Stenosis (cervical/lumbar) (narrowing)	
Hepatitis/Liver disease		Stroke/CVA/TIA	
Herniated invertebral disk		Other:	
HIV/AIDS		Other:	
Hydrocephalus (congenital)/ normal pressure hydrocephalus			
High cholesterol			
Hypertension (high blood pressure)			

Past Surgical History

Please carefully circle all operations you have had in the past, please include approximate dates.

Surgery	Date	Surgery	Date
Appendectomy		Pituitary resection	
Bariatric surgery (weight loss)		Prostate surgery	
Brain bleed surgery		Pseudomeningocele (CSF repair)	
Breast biopsy		Radiosurgery (Gamma or CyberKnife)	
Breast implant		Shunt revision	
Coronary artery bypass graft		Skin surgery	
Cardiac valve surgery		Spinal tumor resection	
Carotid endarterectomy		Spinal fusion	
Carpal tunnel release		Spine surgery	
Clipping/coiling of aneurysm		Splenectomy	
Colon surgery		Stent (Vascular/Renal)	
Coronary stent		Tendon surgery	
Cranioplasty (bone flap)		Thyroid surgery	
Ear tubes		Tonsillectomy	
Eye surgery		Vascular surgery	
G-Tube / PEG placement		Other:	
Gallbladder removal		Other:	
Hernia repair		Other:	
Hysterectomy			
Joint surgery			
Mastectomy			

Have you ever had a blood transfusion or received blood products?

Yes [Date: _____] No

Have you had any problems with anesthesia? Yes No

If yes, please explain: _____

Do you take aspirin, any medicines that contain Aspirin, Ibuprofen, Advil, or Motrin? Yes No

If yes, please list last date taken: _____

Do you take any blood thinners such as Plavix, Coumadin, Lovenox or others? Yes No

If yes, please list last date taken: _____

Family History

If you have any relatives, including children, with serious medical conditions (such as asthma, high blood pressure, heart attacks, kidney problems, diabetes, seizures, strokes, cancers, etc.) please list below.

Family Member	Age (or age at death)	Living = [L] or Deceased = [D]	Medical Condition(s)
Mother			
Father			
Sibling (Sister)			
Sibling (Brother)			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Child(ren)			

Social History

Gender: Male Female **Height:** ____feet ____inches **Weight:** ____lbs. **Birthplace:** _____

Education: High School Vocational School College Graduate Degree

Current Occupation: _____

Marital Status: Single Married Separated Divorced Widowed

Living Arrangement: Alone Roommate(s) Spouse Children Parent(s) Sibling(s)

Alcohol Use: Yes No Drinks/week: _____ Beer Wine Liquor # of years: _____

Cigarette Use: Yes No Packs/day: _____ Smokeless Tobacco: Yes No How Much: _____
# of years: _____ Ready to quit? Yes No Counseling given? Yes No

Illicit Drug Use: Yes No Type of Drug(s): _____
Amount Used/Week: _____

Allergy Information

Drug Allergy

Drug Name	Reaction	Date

Food Allergy

Food	Reaction	Date

Name: _____

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Outpatient Medication List*

Update and give a copy of this list to the patient with each outpatient visit. *Do not use abbreviations.*

☐ Patient taking no medications regularly and none in the past 72 hours.

Medications (including over the counter and herbal medications)	Dose (ex: strength, #of pills or drops)	Route (ex: by mouth, inhaled, on skin)	Frequency (how often)

* *If you have questions about any of your medications, please contact the person who perscribed them.*

Reviewed by: _____ Date / Time: _____

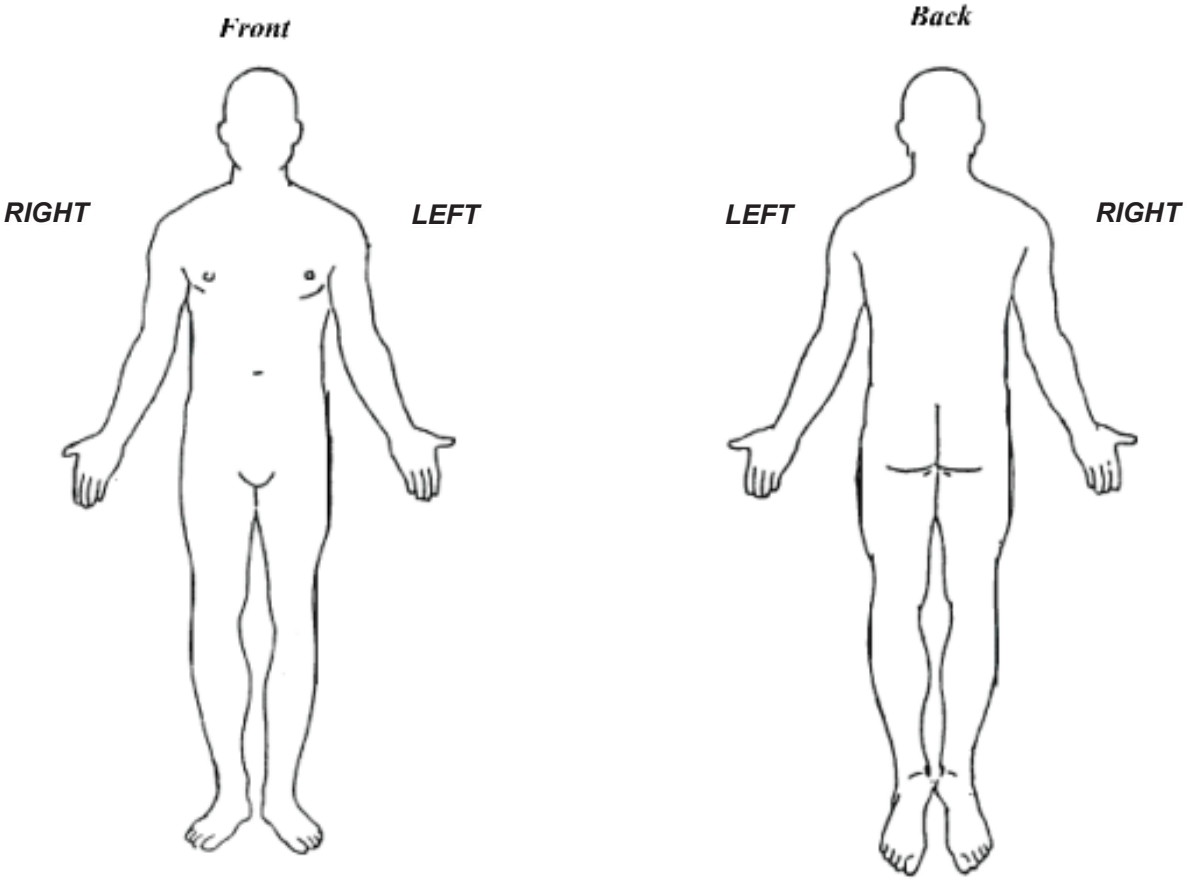
(Name and credentials of health care provider)

Pain Drawing

Where is your pain now?

Mark the areas on your body where you feel the described discomfort using the appropriate symbols.

Ache ^^ Numbness **00** Pins & Needles **||** Burning **XX** Radiating Pain: **//**



Please rate your Arm Pain

0 1 2 3 4 5 6 7 8 9 10
No Pain Moderate Pain Worst Pain

Please rate your Back Pain

0 1 2 3 4 5 6 7 8 9 10
No Pain Moderate Pain Worst Pain

Please rate your Leg Pain

0 1 2 3 4 5 6 7 8 9 10
No Pain Moderate Pain Worst Pain

Please rate your Neck Pain

0 1 2 3 4 5 6 7 8 9 10
No Pain Moderate Pain Worst Pain

Name: _____

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Neck Disability Index

This questionaire is designed to help us better understand how your neck pain affects your ability to manage everyday-life activities. In each section below, please carefully circle ONE number that describes your pain. Although you may consider that two of the statements in any one section relates to you, please circle only ONE number that most closely describes your current situation.

Section 1 – PAIN INTENSITY

0. I have no neck pain at this moment.
1. The pain is mild at the moment.
2. The pain is moderate at the moment.
3. The pain is fairly severe at the moment.
4. The pain severe at the moment.
5. The pain is the worst imaginable at the moment.

Section 2 – PERSONAL CARE

0. I can look after myself normally without causing extra neck pain.
1. I can look after myself normally, but it causes extra neck pain.
2. It is painful to look after myself and I am slow and careful.
3. I need some help but can manage most of my personal care.
4. I need help every day in most aspects of self care.
5. I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – LIFTING

0. I can lift heavy weights without extra neck pain.
1. I can lift heavy weights, but it gives extra neck pain.
2. Neck pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table.
3. Neck pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can only lift very light weights.
5. I cannot lift or carry anything at all.

Section 4 – WORK

0. I can do as much work as I want.
1. I can do only my usual work, but no more.
2. I can do most of my usual work, but no more.
3. I cannot do my usual work.
4. I can hardly do any work at all.
5. I cannot do any work at all.

Section 5 – HEADACHES

0. I have no headaches at all.
1. I have slight headaches that come infrequently.
2. I have moderate headaches that come frequently.
3. I have severe headaches that come frequently.
4. I have headaches almost all of the time.

Section 6 – CONCENTRATION

0. I can concentrate fully without difficulty.
1. I can concentrate fully with slight difficulty.
2. I have a fair degree of difficulty concentrating.
3. I have a lot of difficulty concentrating.

Please complete both sides of the form

Neck Disability Index

Please circle ONE number in each section which most closely describes your problem.

4. I have a great deal of difficulty concentrating.
5. I cannot concentrate at all.

Section 7 – SLEEPING

0. I have no trouble sleeping.
1. My sleep is slightly disturbed for less than 1 hour.
2. My sleep is mildly disturbed for less than 1-2 hours.
3. My sleep is moderately disturbed for up to 2-3 hours.
4. My sleep is greatly disturbed for up to 3-5 hours.
5. My sleep is completely disturbed for up to 5-7 hours.

Section 8 – DRIVING

0. I can drive my car without neck pain.
1. I can drive my car with only slight neck pain.
2. I can drive as long as I want with moderate neck pain.
3. I cannot drive as long as I want because of moderate neck pain.
4. I can hardly drive at all because of severe neck pain.
5. I cannot drive at all because of neck pain.

Section 9 – READING

0. I can read as much as I want with no neck pain.
1. I can read as much as I want with slight neck pain.
2. I can read as much as I want with moderate neck pain.
3. I cannot read as much as I want because of severe neck pain.
4. I cannot read at all.

Section 10 – RECREATION

0. I am able to engage in all recreational activities with no neck pain.
1. I am able to engage in all my recreational activities with some neck pain.
2. I am able to engage in most, but not all of my recreational activities because of pain in my neck.
3. I am able to engage in a few of my recreational activities because of neck pain.
4. I can hardly do recreational activities due to neck pain.
5. I cannot do any recreational activities due to neck pain.

Name: _____

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Oswestry Low Back Pain Scale - Please Complete if You Have Back Pain

Please carefullly circle ONE number in each section which most closely describes your problem.

Section 1 - PAIN INTENSITY

0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 - PERSONAL CARE

0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increases the pain, but I manage not to change my way of doing it.
3. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
4. Because of the pain, I am unable to do some washing and dressing without help.
5. Because of the pain, I am unable to do any washing and dressing without help.

Section 3 - LIFTING

0. I can lift heavy weights without extra pain.
1. I can life heavy weights, but it gives extra pain.
2. Pain prevents me from lifting heavy weights off of the floor, but I can manage if they are conveniently positioned, i.e. on a table.
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can only lift very light weights, at most.
5. I cannot lift or carry anything at all.

Section 4 - WALKING

0. I have no pain with walking.
1. I have some pain with walking, but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 - SITTING

0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than 1 hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 - STANDING

0. I can stand as long as I want without pain.
1. I have some pain with standing, but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour with out increasing pain.

Please complete both sides of the form

Oswestry Low Back Pain Scale - Please Complete if You Have Back Pain

Please carefully circle ONE number in each section which most closely describes your problem.

3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes
5. I avoid standing because it increases pain immediately.

Section 7 - SLEEPING

0. I get no pain in bed.
1. I get pain in bed, but it does not prevent me from sleeping well.
2. Because of my pain, my normal night's sleep is reduced by less than ¼.
3. Because of my pain, my normal night's sleep is reduced by less than ½.
4. Because of my pain, my normal night's sleep is reduced by less than ¾.
5. Pain prevents me from sleeping at all.

Section 8 - SOCIAL LIFE

0. My social life is normal and gives me no pain.
1. My social life is normal, but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I hardly have any social life because of the pain.

Section 9 - TRAVELING

0. I get no pain when traveling.
1. I get some pain when traveling, but it does not compel me to seek alternate forms of travel.
2. I get extra pain when traveling, but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling, which compels me to seek alternate forms of travel.
4. Pain restricts me to shorten necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 - CHANGING DEGREE OF PAIN

0. My pain is rapidly getting better.
1. My pain fluctuates, but is definitely getting better.
2. My pain seems to be getting better, but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.