Mercy Clinic Neurosurgery
Spine Health History Form

Please fill out this form completely and **MAIL/EMAIL/FAX IT BACK 2 DAYS PRIOR TO YOUR VISIT** so that we can learn about you and best decide how to treat your condition. Additionally, please bring your insurance card, driver's license or identification card, CD of your prior imaging, and previous reports of any neurological or neurosurgical testing or consultations to your visit.

Name _____ DOB_____ Age _____

Address _____

Email _____

Phone # (H) _____ (W) _____ (C) _____

Emergency Contact: _____ Phone #: _____

Referring Physician: Primary Physician: ☐ same as referring physician

Name _____ Name _____

Phone #: _____ Phone #: _____

Specialty _____

Please list any other physicians you would like us to notify:

_____

Preferred Pharmacy: _____ Phone#: _____

History of Present Illness

Chief Complaint (the one **main** problem/symptom for seeing us today)

_____

Where is your problem? What body parts are affected? Please be specific.

_____

_____

How long ago did your problem begin? _____

Did this result from an injury (please describe if so)? _____

Is it constant, or does it "come and go"? _____

How severe is your problem/symptom today? (please circle) mild moderate severe

If you have pain, how severe is it from 0 (no pain) to 10(worst imaginable)? _____

If pain/sensory abnormality, how would you describe it? (Circle any that apply)

Aching Dull Sharp Throbbing Shooting Pressure Burning Pins/needles Tingling

_____

What percentage of pain is in your neck and what percentage is in your arm(s)?

_____%Neck _____%Arm(s)

What percentage is in your back and what percentage is in your leg(s)?

_____%Back _____%Leg(s)

What circumstances, activities or positions **worsen** your problem/symptoms?

_____

What circumstances, activities or positions **lessen** (even temporarily) your problem/symptoms?

_____

Do you have clumsiness in your hands such as problems with manipulating fine objects like picking up change or buttoning your shirt? If so, please describe:

_____

Do you have any other symptoms that may be related to your main problem? (Examples: numbness, tingling, weakness, incontinence, stumbling/falls, leg fatigue with rapid movements, unable to stand up straight)

_____

_____

Have You Tried?	Type	Length of Time
Over-the-Counter Pain Meds		
Muscle Relaxants		
Prescription Pain Meds		
Nerve Pain Meds		
Lidocaine patches		
Heat/Ice		
Massage		
Home Exercise		
Physical Therapy/Yoga		
Pain Management/Injections		
Traction/Inversion Table		
Chiropractics		
Other (acupuncture, etc.)		

Is this a workman's compensation case? Yes No

Is this related to a personal injury or car accident? Yes No

Are you currently involved in any litigation or lawsuits? Yes No

Have you consulted a lawyer about your injury/problem? Yes No

Have you ever seen a spine surgeon before (Name)? Yes No _____

Have you ever seen a spine surgeon for your current problem? Yes No _____

Medical problems. Have you ever been diagnosed with, treated by a physician, or taken medications for any of the following medical conditions?

Past Medical History	Y	N		Y	N
Anemia			Autoimmune Disease		
Bleeding/Clotting Disorder			Gout		
Cancer – *Type?*_____			Rheumatoid Arthritis		
Chronic Steroid Use			Osteoarthritis		
High Cholesterol			Osteoporosis or osteopenia, T-score___		
Hypertension			Bone or connective tissue disease		
Diabetes ☐Adult ☐Juvenile			Scoliosis		
Arrythmia / Atrial Fibrillation			Anxiety/Depression		
Heart Attack			Bipolar/Schizophrenia/Psychosis		
Heart Disease			Chronic Headaches / Migraines		
Congestive Heart Failure			Convulsions (seizures)		
Heart Valve Problems			Stroke		
COPD			Brain Disease _____		
Sleep Apnea			Thyroid Disorder		
Asthma			DVT/PE _____		
Tuberculosis			Skin disorder		
HIV or AIDS			Kidney Disease		
Hepatitis ☐B or ☐C			Prostate Disease		
Depressed Immune System			Gastro-intestinal bleeding		
Major Infection _____			Gastric reflux (GERD)		

Females: Are you now pregnant? ☐ Yes ☐ No

Please use this space to elaborate on any of the above or include other diagnoses if needed:

_____

_____

Past Surgical History (PSHx)		
Spine Surgeries	**Surgeon**	**Date**

Any complications from any of the procedures listed above?

_____

Past Surgical History (PSHx)	
Other Surgeries	**Date**

Have you had any problems with anesthesia in the past? ☐ Yes ☐ No
If yes, please explain:

_____

Family Medical History (FMHx)										
	Mother	Father	Brother	Sister	Grandmother (maternal)	Grandmother (paternal)	Grandfather (maternal)	Grandfather (paternal)	Aunt	Uncle
Brain Aneurysm										
Cancer-- ***Type?***										
Diabetes										
High Cholesterol										
High Blood Pressure/ Hypertension										
Heart Disease										
Tobacco Use										
Spinal Stenosis										
Blood Clots										

Social History (SHx)				
Alcohol Use	Never	Current	Former	Date Quit
Tobacco Use	Never	Current	Former	Date Quit
	Average packs per day?			Chewing tobacco? Yes No
Drug Use	Yes	No	Type:	
Occupation			Retired?	Unemployed?
Disabled?	Yes	No	Reason:	Date:
Marital Status	Married	Divorced	Single	Widowed

Medications (Please include over the counter meds – attach list if necessary)			
Drug	Dosage	Frequency & Length of Time	Reason

Allergies	Reaction
Medications? No Yes (please list below):	
Latex? No Yes (please describe):	
Iodine? No Yes (please describe):	
Metals? No Yes (please describe):	
Foods? No Yes (please describe):	

Review of Systems

Please check any of the medical condition(s) below which apply to you. If none, check here: ☐

Constitutional
☐Change in appetite
☐Excessive sleepiness
☐Fatigue
☐Fever/Chills
☐Night Sweats
☐Recent sore throat
☐Unexpected weight loss

Eyes
☐Light Sensitivity
☐Blurred vision
☐Double vision
☐Peripheral vision loss
☐Visual impairment
☐Macular degeneration
☐Cataracts
☐Glaucoma

Ears, Nose, & Throat
☐Hearing loss
☐Clear drainage for ears
☐Clear drainage for nose
☐Ringing in ears
☐Sinus disease
☐Trouble swallowing

Cardiovascular
☐Chest pain/pressure
☐Fainting
☐Heart defect
☐Heart murmur
☐High blood pressure
☐Low blood pressure
☐Leg Swelling
☐Palpitations

Respiratory
☐Bronchitis
☐Chronic cough
☐COPD
☐Emphysema
☐Pneumonia
☐Shortness of breath
☐Trouble breathing
☐Wheezing

Gastrointestinal
☐Nausea
☐Vomiting
☐Black or bloody stool
☐Constipation
☐Diarrhea
☐Heartburn
☐Ulcer
☐Loss of control

Skin
☐Birth marks
☐Psoriasis
☐Skin rashes
☐Melanoma
☐Abnormal stretch marks

Endocrine
☐Dry eyes/mouth
☐Endocrine disorder
☐Low blood sugar
☐Pituitary disorder
☐Sickle cell disease
☐Abnormal cycles
☐Leaking from breasts
☐Easy bruising/bleeding

Genitourinary
☐Blood in urine
☐Change in habits
☐Recurrent infection
☐Kidney stones
☐Loss of control
☐Painful urination
☐Urinary urgency

Musculoskeletal
☐Connective tissue
☐disorder
☐Low back pain
☐Neck pain
☐Joint pain
☐Joint replacement
☐Joint swelling
☐Lymph node swelling
☐Muscle aches

Neurological
☐Altered taste/smell
☐Balance difficulty
☐Clumsiness
☐Concussion
☐Confusion
☐Concentration difficulty
☐Dizziness
☐Falls
☐Facial pain
☐Hallucinations
☐Headache
☐Loss of consciousness
☐Memory problems
☐Muscle twitching
☐Nausea
☐Numbness
☐Personality change
☐Shooting pains
☐Speech difficulty
☐Tingling sensation
☐Tremors
☐Vertigo
☐Walking difficulty
☐Weakness

Psychological
☐Substance abuse
☐Suicidal thoughts