BRAIN AND SPINE SURGERY

POUDRE VALLEY MEDICAL GROUP

Fort Collins, Colorado

PATIENT MEDICAL HISTORY

Name *(Please print using ink throughout this form)* Date

We ask that you complete this form to help the doctor determine your diagnosis and treatment plan. Please be very specific. Much of this information will also be vital in processing your insurance claim. *Please answer every question even if your answer is "no" or "N/A" (not applicable).*

1. What kind of symptoms are you having? ____________________

2. How long have you had these symptoms? (Be specific about onset.) ____________________

3. Please circle a number from 1 to 10 that most closely measures the level of pain you feel regularly.

hardly noticeable	1	2	3	4	5 *noticeable and wearing*	6	7	8	9	10	*I can barely tolerate it*

4. Please circle a number from 1 to 10 that most closely measures the level of pain you feel occasionally.

hardly noticeable	1	2	3	4	5 *noticeable and wearing*	6	7	8	9	10	*I can barely tolerate it*

5. Do you have any numbness or tingling in your arms or legs? (Please describe.) ____________________

6. Do you have any weakness in your arms or legs? (Please describe.) ____________________

7. Please check any of the following treatments you have tried to relieve your symptoms:

- ☐ pain medication
- ☐ cervical or lumbar traction
- ☐ back brace
- ☐ heat
- ☐ pain control clinic
- ☐ steroid injections
- ☐ physical therapy (PT)
- ☐ bed rest
- ☐ muscle relaxants
- ☐ exercise program
- ☐ cervical collar
- ☐ ultrasound
- ☐ TENS unit
- ☐ oral steroids
- ☐ reduction of activity
- ☐ anti-inflammatory medications
- ☐ chiropractic treatment
- ☐ hydrotherapy
- ☐ massage therapy
- ☐ work-hardening program
- ☐ others: ____________________

____
Number of weeks or months you have had physical therapy

8. Please name any physicians whom you have seen about your current medical problem or any similar problem. ____________________

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9. Has anyone in your family ever had the same or similar problem? (Please list who and what type of problem.) ______

10. If your symptoms are related to any injury, please mark the box below indicating the type of injury.
    Date of injury: ____________________ ☐ auto injury ☐ personal injury ☐ work-related injury
    ☐ other ____________________ Describe the accident and injury completely. If work-related, please tell why.

11. Are you working now? What are the physical requirements of your job? (Describe what you do physically during your work day.) ____________________
    Specifically, what amount and kind of lifting, if any, are you required to do? ____________________

    Do you have any medical work-related restrictions? (Pleae describe.) ____________________

12. If you stopped working because of symptoms related to this injury, when did you stop working? ____________________

13. Why did you stop working?____________________

14. Please list all current medications and the reason (diagnosis) for taking them.

Medication	Reason for taking medication
A.	
B.	
C.	
D.	
E.	
F.	

My preferred pharmacy is: ____________________
Area code and phone number

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15. Do you take ☐ ASPIRIN, ☐ MOTRIN, ☐ IBUPROFEN, ☐ NAPROSYN, ☐ RELAFEN, ☐ ORUVAIL, ☐ ADVIL, or any other anti-inflammatory medicine? If so, please list. ______

16. Do you take ☐ COUMADIN (WARFARIN), ☐ PLAVIX, or any other blood thinners? ☐ Yes ☐ No
    If so, please list. ______

17. Do you take any supplements, herbs, or vitamins? If so, please list. ______

18. Have you ever had any brain or spine surgery? ☐ Yes ☐ No If yes, please give dates, reasons, and name(s) of surgeon(s). ______

19. Please list ***ANY*** other past operations you have undergone during the last 10 years. Please give dates if you remember them. ☐ No other surgeries in the past 10 years.
    A. ______ C. ______
    B. ______ D. ______

20. Please list ***ANY*** medication ALLERGIES. ☐ No known allergies.
    A. ______ C. ______
    B. ______ D. ______

21. Are you allergic to IODINE? ☐ Yes ☐ No ☐ Don't know

22. Are you allergic to LATEX? ☐ Yes ☐ No ☐ Don't know

23. Do you smoke? If so, how much? ______

24. Do you drink alcohol? If so, how much? What kind? ______

25. Please state:

    Height: ______

    Weight: ______

    Date of birth: ______

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Please check the box if you have experienced any of the following in the past 5 years.

Past Medical History

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Blood clot
- ☐ Cancer
- ☐ Coronary heart disease
- ☐ COPD
- ☐ Diabetes meilitus
- ☐ Gallbladder disease
- ☐ Glaucoma
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Osteoporosis
- ☐ Heart murmur
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Peptic ulcer
- ☐ Respiratory disorder
- ☐ Seizure disorder
- ☐ Sinusitis
- ☐ Thyroid disorder
- ☐ Urinary tract infection

Symptoms & Illnesses

- ☐ Corrective lenses
- ☐ Double vision
- ☐ Blurry vision
- ☐ Blindness
- ☐ Other eye symptoms
- ☐ Hearing loss
- ☐ Ringing in the ears
- ☐ Difficulty swallowing
- ☐ Other ear, nose or throat symptoms
- ☐ Chest pain/discomfort
- ☐ Fast heart rate
- ☐ Other cardiovascular symptoms
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ Other pulmonary symptoms
- ☐ Neck pain
- ☐ Back pain
- ☐ Headache
- ☐ Difficulties in speech
- ☐ Memory lapses or loss
- ☐ Motor disturbances
- ☐ Seizures
- ☐ Dizziness
- ☐ Other neurological symptoms
- ☐ Pain in the arms
- ☐ Pain in the leg
- ☐ Other musculoskeletal symptoms
- ☐ Easy bleeding
- ☐ Easy bruising tendency
- ☐ Other hematologic symptoms
- ☐ Depression
- ☐ Anxiety
- ☐ Sleep disturbances
- ☐ Feeling restless/agitated
- ☐ Claustrophobia
- ☐ Other psychological symptoms
- ☐ Weight change
- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Abnormal appetite
- ☐ Other constitutional symptoms
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Black/bloody stools
- ☐ Abdominal pain
- ☐ Other gastrointestinal symptoms
- ☐ Pain w/urination
- ☐ Bloody urine
- ☐ Loss of control (leaking)
- ☐ Urination at night
- ☐ Other genitourinary symptoms

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