ARIZONA SPINE CARE

Orthopedic New Patient Questionnaire

Name:_____ Today's Date: _____
Date of Injury: _____ Height:____ ft____in Weight:_____
AZ Spine Care MR# _____ Date of Birth: _____

1. What are you here for today? _____

   a. Where is your pain/injury? _____

2. How and when did your injury begin?_____
_____

3. Did you have any other injuries or related problems?_____

4.	**Medications:**	**Dosages:**	**Frequency:**

5. **Please list your local pharmacy & Location**: _____

6. **Are you allergic to any medications:** Please Check: Yes_____ No_____
   Medication_____ Reaction_____
   Medication_____ Reaction_____
   Medication_____ Reaction_____

Past Medical History

7. **Please mark any of the following medical problems you have had:**

____ 1. Ulcers	_____2. Prostate problems
____ 3. Ulcerative colitis	_____4. Hepatitis type:_____
____ 5. Psoriasis	_____6. Diabetes type:_____
____ 7. Arthritis (not spine related)	_____8. Heart disease/heart attack
____ 9. Tuberculosis	_____10. Stroke
____ 11. Cancer	_____12. Asthma
____ 13. HIV positive	_____14. Depression
____ 15. Seizure	_____16. High Blood Pressure
____ 17. Kidney / Bladder infections	_____18. Other_____
____19. Kidney Stones	_____20. None

8. **Have you been hospitalized within the past 5 years? Why? When?:**_____

_____

_____

9. **List all previous surgeries: NONE:**_____

Date of surgery	Type of surgery	Describe recovery
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History: (Does any member of your biological family have one or more of these conditions?)

10. Please ***mark*** any conditions that may apply to your immediate family: **NONE:** _____

____Cancer ____Diabetes ____Heart Disease ____Stroke
____Arthritis ____Back Pain ____Bleeding tendencies ____Anesthesia difficulties
____Malignant hyperthermia

11. **Social History:**

1. Do you ***currently*** smoke cigarettes?
   (Check only ONE statement)
   - ____ 1. I have never smoked
   - ____ 2. Yes: _____ packs per day
   - ____ 3. No, I quit within the last 6 months
   - ____ 4. No, I quit more than 6 months ago

2. Substance Abuse?
   (Check only ONE statement)
   - ____ 1. No
   - ____ 2. Yes, once in a while
   - ____ 3. Yes, often

   If yes, type _____
   Amount _____

3. Do you use alcoholic beverages (beer, wine, liquor)?
   (Check only ONE statement)
   - ____ 1. No
   - ____ 2. Yes, once in a while
   - ____ 3. Yes, often

   If yes, type of alcohol beverage_____
   Amount _____

Are you currently employed? ☐ **Yes** ☐ **No** ☐ **Retired**
What is your occupation? _____
Last date worked: _____

12. Race: White_____ African American ____ Pacific Islander _____ Asian _____Other:_____
Ethnicity: Hispanic____ Non-Hispanic_____

13. REVIEW OF SYSTEMS:

For office use only: Patient DOB: _____-_____-_____ AZ Spine MR#:_____

Please **MARK "X"** next to your current symptoms:

1. Skin:
   - ____rashes
   - ____psoriasis
   - ____bruise easily
   - ____abnormal lumps
   - ____painful breasts

2. Respiratory:
   - ____shortness of breath
   - ____wheezing
   - ____cough/ sputum production

3. Genitourinary:
   - ____blood in urine
   - ____increased frequency of urination
   - ____painful urination
   - ____loss of bladder control
   - ____kidney stones

4. Eyes:
   - ____visual
   - ____double vision

5. Gastrointestinal:
   - ____weight loss
   - ____abdominal pain
   - ____nausea/vomiting
   - ____diarrhea or constipation
   - ____blood in stool
   - ____loss of bowel control

6. Ears
   - ____decreased hearing
   - ____ringing in ears

7. Musculoskeletal:
   - ____fractures/sprains
   - ____osteoporosis
   - ____joint swelling

8. Nose
   - ____breathing problems
   - ____sinus problems

9. Throat
   - _____sore throat
   - _____hoarseness
   - _____snoring

10. Endocrine:
    - ____enlarged thyroid/goiter
    - ____excessive thirst/appetite
    - ____diabetes

11. Cardiovascular:
    - ____palpitations
    - ____irregular heartbeat
    - ____heart murmur
    - ____rheumatic fever
    - ____chest pain

12. Neurological:
    - ____headache/migraine
    - ____dizziness
    - ____convulsions/seizures
    - ____loss of consciousness

13. Was this a work related injury?_____

14. Who referred you to Arizona Spine Care?
    - ____ 1. Primary doctor
    - ____ 2. Physical therapist
    - ____ 3. Patient
    - ____ 4. Other

    Name:_____
    Address:_____
    _____
    Phone:_____ Fax:_____

If a doctor requested you visit Arizona Spine Care, please sign below if you wish to authorize the release of this and all subsequent reports to the above named physician

*I Authorize this release/Signature:*_____

Check here if you do NOT authorize this release: ☐

15. Have you been treated by a physical therapist for this injury? _____1. Yes _____2. No

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