University of Connecticut
Health Center
UCONN Medical Group
Department of Orthopaedic Surgery

Patient Identification

Comprehensive Spine Surgery New Patient Questionnaire

Conf # _____

Name:_____ **DOB**:_____ **Age**:_____ **Sex**: M □ F □

CHIEF COMPLAINT: Right □ Left □ _____
_____Accident Related □ Work Related □

Onset of problem: _____

1. **Pain level** (please circle) no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain
2. Has the pain **DECREASED/INCREASED/SAME** (by how much [%])

   Leg _____Back_____ Neck_____ Arm_____
3. **Quality of the pain**: Ache __ Burning __ Stabbing __ Pressure __ Other __
4. **Pain duration**: *All the time __ Most of the time __ Some of the time __ Not present all the time __*
5. Please check only **one** choice given below:

□ I have only back pain	□ Leg pain worse than back pain	□ I have only arm pain	□ Neck pain equal to arm pain
□ I have only leg pain	□ Back pain equal to leg pain	□ Neck pain worse than arm pain	
□ Back pain worse than leg pain	□ I have only neck pain	□ Arm pain worse than neck pain	

6. Do you have tingling? YES __NO __ Where _____
7. Do you have numbness? YES __NO __ Where_____
8. Do you have weakness? YES __NO __ Where_____
9. Pain is **EXACERBATED** by:
   sitting __standing __walking __lifting __bending __ extending __driving __lying on back __
10. Pain is **DECREASED** by:
    sitting __standing __walking __lifting __bending __ extending __driving __lying on back __

Past Treatment: _____

Allergies: List all medications and substances to which you are allergic (include reaction):

☐None	☐ Penicillin	☐Sulfa	☐Iodine	☐ Latex	☐Aspirin
☐Other					

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Medical Problems: Check all of the medical problems you have had in your lifetime:

□	High Blood Pressure	□	Irregular Heart Rhythm	□	Coronary Heart Disease
□	Heart Attack	□	Heart Valve Disease	□	Peripheral Vascular Disease
□	Blood Clots	□	Asthma	□	Lung Disease
□	Tuberculosis (TB)	□	Diabetes	□	Thyroid Disease
□	Kidney Disease	□	Cancer	□	Hepatitis □ A □ B □ C
□	Stomach Ulcer/GERD	□	Diverticulitis	□	Osteoporosis
□	Arthritis	□	Seizures	□	Stroke
□	Brain Injury	□	Polio	□	Spinal Cord Injury
□	Cerebral Palsy	□	Multiple Sclerosis	□	Parkinson's Disease
□	Nerve Injury	□	Injury	□	Other (list)
□	Obstructive Sleep Apnea	□	Snoring	□	Daytime sleepiness

Current Medications: List all current medications and herbal medications you are taking:

Medication	Dose	Frequency	Medication	Dose	Frequency

Surgical History: List all the operations you have had in your life:

Year	Type of Operation	Year	Type of Operation

Review of Systems: Any current or recent problems with the following?:

	Yes	No	Describe all yes answers
Eyes, Vision	□	□	
Ears, Nose, Throat	□	□	
Lungs, Breathing	□	□	
Digestion, GI Problems	□	□	
Bowel, Bladder Problems	□	□	
Heart Ailments	□	□	
Bleeding Problems	□	□	
Blood Clots	□	□	
Blood Transfusions	□	□	
Balance Problems	□	□	
Numbness, Tingling	□	□	
Blackouts, Fainting	□	□	

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Epilepsy, Seizures	□	□	
Muscle Weakness	□	□	
Muscle Spasms, Spasticity	□	□	
Psychological Problems	□	□	
Arthritis	□	□	
Diabetes, Blood Sugar	□	□	
Weight Loss or Gain	□	□	
Infections	□	□	
Fevers, Chills	□	□	
Night Sweats	□	□	
Other	□	□	
	□	□	

Social History:

Occupation	Full time □ Part-time □ Retired □
Do you currently use tobacco?	Yes □ No □
Did you previously use tobacco?	Yes □ No □
Cigarettes □ _____packs/day	Pipe □ Cigar □
Chewing tobacco	For how long? _____yrs
Do you drink alcohol?	Yes □ No □ How Often? Daily □ 2x/wk □ 1-2x/mo □ 1-2x/yr □
History of substance abuse?	Yes□ No□ What substance?_____

Family History: Do you have any blood relatives with any of the following conditions?
(Please indicate family member: i.e. Mother =M, Father =F, Brother =B, Sister=S)

□	High Blood Pressure	□	Irregular Heart Rhythm	□	Coronary Artery Disease
□	Heart Attack	□	Heart Valve Disease	□	Peripheral Vascular Disease
□	Blood Clots	□	Stroke	□	Diabetes
□	Asthma	□	Lung Disease	□	Tuberculosis (TB)
□	Thyroid Disease	□	Kidney Disease	□	Cancer
□	Hepatitis A□ B□ C□	□	Osteoporosis	□	Arthritis
□	Seizures	□	Other (list)		

Signature_____Date_____Time_____

MD Signature _____Date_____Time _____

VITALS: Temp_____ BP_____ HR_____ HT_____ WT _____

Medical Assistant signature: _____ Date: _____Time_____

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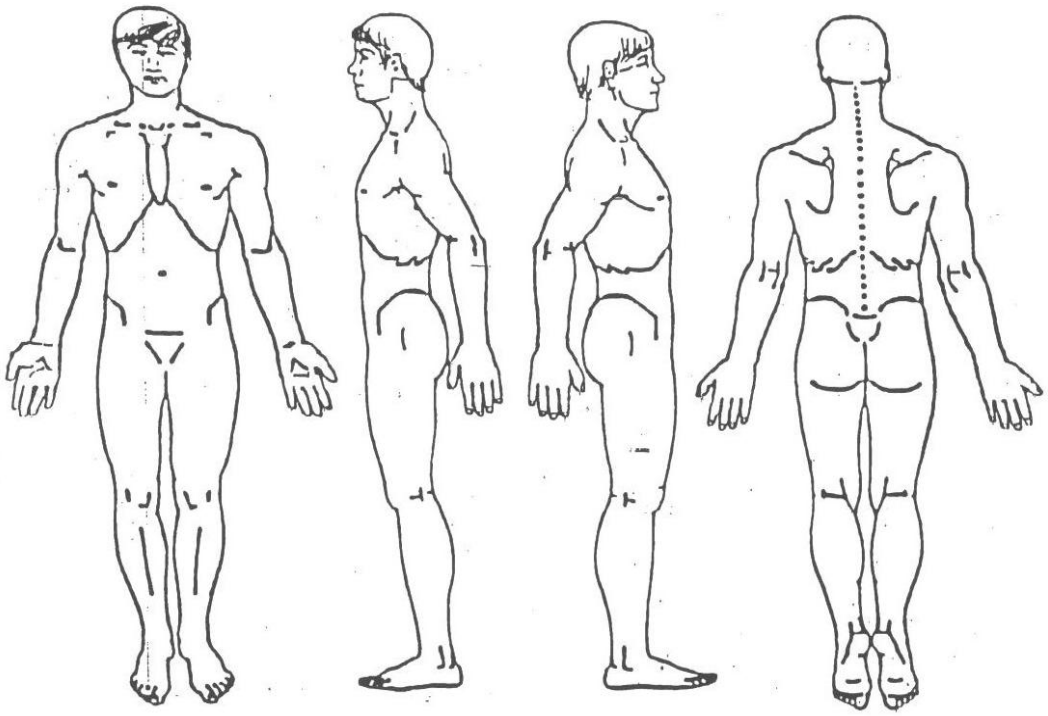
Please mark the location of your pain on the body and mark how severe it is on the pain line at the bottom of the page. Also please note if the pain is aching, burning, stabbing, whether you feel pins & needles, numbness or any other symptom.



0% No Pain — 100% Worst possible pain

Signature: _____ Date/Time _____

Reviewed by _____ Date/Time _____