Mount Sinai West

SPINE SURGERY
NEW PATIENT QUESTIONNAIRE

Patient Name: _____ **Date of Birth:** _____ **Age:** _____ **Gender:** M F T

Email: _____ **Preferred phone:** _____

Referred by: ☐Self ☐Family ☐Friend ☐Insurance Company ☐Physician: _____

Referring Physician: _____ **Tel#** _____ **Fax#** _____

Reason for visit: ☐CERVICAL/NECK ☐ARM ☐LUMBAR/BACK ☐LEG ☐SCOLIOSIS ☐ OTHER: _____

Which side: ☐RIGHT ☐LEFT ☐BOTH **What is your dominant side:** ☐RIGHT ☐LEFT ☐AMBIDEXTROUS

Is this related to a workers' compensation or no-fault claim? ☐NO ☐YES **Claim#** _____

Is your condition due to a specific injury? ☐YES ☐NO **If no, was the onset:** ☐GRADUAL ☐SUDDEN

When did your condition start? (date) _____

Please briefly describe the injury or onset of the condition: _____

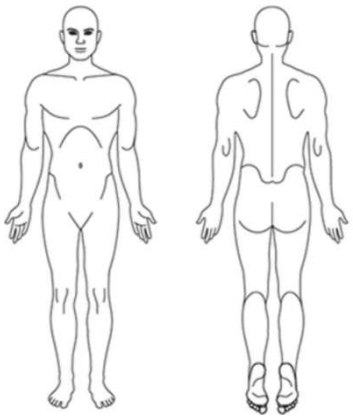
_____

If you have had other spine related injuries or surgeries, please describe: _____

_____

Please list any previous SPINE surgery (ies)?: _____

1Please draw where your problems are:



Please rate your pain on scale 1-10 (10 most severe) Now: _____**At its worst:** _____

Is there pain? ☐NO ☐**YES:** ☐CONSTANT ☐INTERMITTENT

Describe the quality of the pain (circle all that apply):

☐DULL ☐ACHY ☐SHARP ☐BURNING ☐TINGLING

Are there associated symptoms? ☐PAIN AT NIGHT ☐STIFFNESS ☐SWELLING

☐INSTABILITY ☐WEAKNESS ☐RADIATING ☐"ELECTRIC SHOCKS"

☐NUMBNESS/TINGLING ☐Other: _____

What makes it better? _____

What makes it worse? _____

Have you had prior: ☐X-RAY ☐MRI ☐CT ☐EMG ☐OTHER _____

When were they taken? _____

Have you tried any previous treatments?

☐TYLENOL ☐ADVIL ☐NSAIDS ☐PHYSICAL THERAPY ☐ OTHER: _____

☐EPIDURAL OR TRIGGER POINT INJECTIONS (Date(s)): _____

Are you allergic to iodine: ☐Yes ☐No **Latex:** ☐Yes ☐No **Metals, or nickel:** ☐Yes ☐No

OTHER ALLERGIES (Foods or medicine and reaction): _____

CURRENT MEDICATIONS (list all medications, vitamins, supplements):

PAST SURGICAL HISTORY AND/OR HOSPITALIZATION

Type of operation / reason for hospitalization	*Approx Date*

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Have you ever had a issues with anesthesia and/or surgery? ☐Yes ☐No Problem: _____
MEDICAL HISTORY (CIRCLE any past or current medical conditions below)

Anxiety	Diabetes	Infection	Pulmonary embolus
Arrhythmia	Gout	Kidney disorder	Reflux
Asthma	Heart attack	Low acting thyroid	Rheumatoid arthritis
Bleeding problems	Heart failure (CHF)	Open wounds / Ulcers	Seizures
Blood clots (DVT-PE)	Hepatitis	Osteoarthritis	Stomach ulcers
Cancer	High blood pressure	Osteoporosis	Stroke
Coronary heart disease	High cholesterol	Peripheral vascular disease	Other:
Depression	HIV / AIDS	Pneumonia	

Are you currently on any blood thinners? ☐NO ☐YES, Which one(s): _____
Have you ever had a MRSA or post operative infection? ☐NO ☐YES If yes explain: (s): _____
Do you have any of the following medical devices:
☐Pain pump ☐Neurostimulator ☐Pacemaker or debrillator ☐Shunt for hydrocephalus
Have you been taking opioids, narcotics, anxiety or antidepressants for 3+ months? ☐NO ☐YES
FAMILY HISTORY
Please CIRCLE if any of your family (parents, siblings, grandparents) have a history of any of the following:

Diabetes	Abnormal bleeding
Heart disease	Rheumatoid arthritis
Cancer & Type: _____	Anesthesia complications

SOCIAL HISTORY
Do you smoke tobacco? ☐NO ☐YES ☐PAST? Quit date: _____ # packs per day_____ # of years: _____
Do you drink alcohol? ☐NO ☐YES How many drinks per week? ___ **History of substance abuse?** ☐NO ☐YES
List any recreational activities / sports you are involved in: _____
Current occupation? _____ **With whom do you live?** _____
REVIEW OF SYSTEMS (Have you had any of the following in the past year?)

Constitutional	**Hematologic**	**Respiratory**	**Skin**
Fever	Easy bruising / bleeding	Cough	Sores / ulcers
Chills	Blood clots in legs	Difficulty breathing	Hives
Night sweats	Blood clots in lungs	Wheezing	Rash
Weight Change		Excessive snoring	Mole changes
ENT	**Cardiovascular**	**Endocrine**	**Musculoskeletal**
Headaches	Chest pain	Cold intolerance	Joint pain
Hearing loss	Palpitations	Heat intolerance	Joint swelling
Glaucoma	Leg swelling	Excessive thirst	Joint stiffness
Dry eyes	Poor circulation		Muscle spasm
Mouth sores	Cold hands / feet		Muscle weakness
Gastrointestinal	**Genitourinary**	**Neurologic**	**Psychiatric**
Abdominal pain	Bladder incontinence	Seizures	Depression
Heartburn	Blood in urine	Dizziness	Anxiety
Difficulty swallowing	Painful urination	Numbness	Memory problems
Constipation	Urinary retention	Paralysis	Insomnia

I hereby certify the above is true and accurate to best of my knowledge.

Patient Name: _____ Patient Signature _____ Date: _____
Reviewed by: _____ Date: _____