APM SPINE & SPORTS PHYSICIANS

Medical History Questionnaire

DATE: _____

Name: _____ Age: _____ years ☐ Right-Handed ☐ Left Handed

Referring Physician: _____

Other Physician: _____

City of Residence: _____

Reason for Visit: _____

Please take a few minutes to complete this form to help us properly address your concerns.

DESCRIBE THE LOCATION OF YOUR PAIN:

Describe your pain: ☐ Aching ☐ Burning ☐ Stabbing ☐ Sharp ☐ Shooting ☐ Numbness ☐ Pulsating ☐ Other: _____

Does the pain shoot or refer to another part of the body? ☐ Yes ☐ No Where? _____

Is the pain: ☐ Constant ☐ Intermittent ☐ Occasional

How many hours per day do you have pain? _____ Hours/day

How long have you been in pain? _____

Do you occasionally need to stop all activities because of pain? ☐ Yes ☐ N o

If yes, number of times? ☐ Daily _____ ☐ Weekly _____ ☐ Monthly _____ ☐ Yearly _____

Have you ever previously experienced this type of pain? ☐ Yes ☐ No

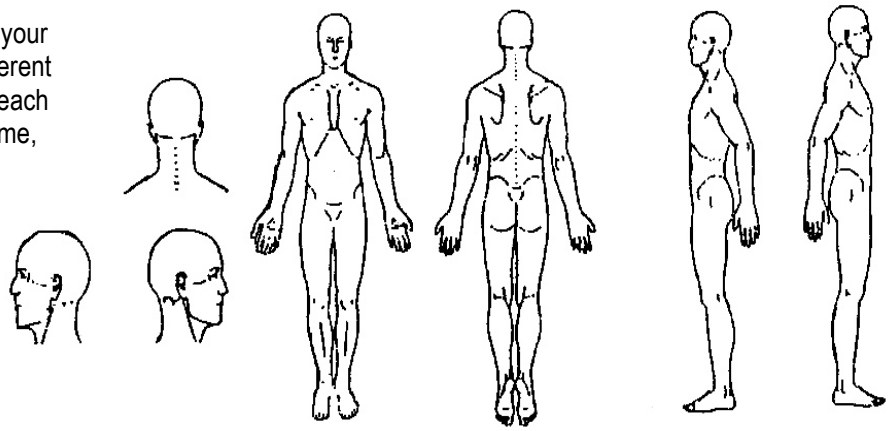
If so, what was done for you? _____

Pain Analog Scale:	*No Pain*	*Minimal*	*Moderate*	*Intense*	*Emergency*
	0	*1 2 3*	*4 5 6*	*7 8 9*	*10*

Please rate your pain: **Today:** ____/10 **Average day**: ____/10 **Good Day**: ____/10 **Bad Day** ____/10

Pain Diagram: Please mark the areas of your pain. You may use the key to indicate different kinds of pain sensations. Please number each painful area in order of the most troublesome, i.e., 1-10 on the diagram.

Key:
- → - **shooting**
- /// - **stabbing**
- xxx - **aching**
- 000 - **throbbing**
- ••• - **pins & needles**
- *** - **burning**



Was there an initiating event for your pain? ☐ Yes ☐ No. Please describe the event and any initial treatment.

_____

_____

_____

_____

_____

Alleviating Factors: What makes your pain better? (please check all that apply)

☐ Rest	☐ Movement	☐ Lying down	☐ Sleep	☐ Traction
☐ Walking	☐ Heat	☐ TENS	☐ Sitting	☐ Massage
☐ Standing	☐ Exercise	☐ Medication	☐ Stretching	☐ Nothing

☐ Other : _____

Exacerbating Factors: What makes your pain worse? (please check all that apply)

☐ Movement	☐ Lying down	☐ Sleep	☐ Walking	☐ Sitting
☐ Standing	☐ Exercise	☐ Stretching	☐ Lack of sleep	☐ Lifting
☐ Coughing	☐ Sneezing	☐ Tension	☐ Reaching over head	☐ Bending
☐ Getting out of a chair	☐ Other: _____			

Sleep

Do you have severe night time pain? ☐ Yes ☐ No

Do you wake up in the middle of the night because of pain? ☐ Yes ☐ No If yes, how many times/night? _____

Do to take sleeping medications? ☐ Yes ☐ No Do you have difficulty falling asleep at night? ☐ Yes ☐ No

Exercise and Activity Level

Please describe your usual daily routine: _____

Describe your regular exercise routine and frequency : ☐ Regular walking ☐ Stretching exercises

☐ Strengthening exercises ☐ Aerobics ☐ Biking ☐ Running

☐ Other: _____

Do you like to exercise? ☐ Yes ☐ No Do you have time to exercise? ☐ Yes ☐ No

Do you have access to a community fitness facility? ☐ Yes ☐ No Where? _____

***Please complete the following section ONLY IF you were involved in a motor vehicle accident.*

☐ **Motor Vehicle Accident**: Date of Accident: _____

You were the ☐ Driver ☐ Passenger in the ☐ front ☐ rear Wearing a seat belt ☐ Yes ☐ No

You were ☐ rear-ended by another vehicle ☐ rear-ended another vehicle ☐ Involved in a head on collision

You were ☐ T-boned ☐ by another vehicle ☐ Driver's Side ☐ Passenger's side ☐ You T-boned another vehicle

You were ☐ side-swiped driver's side ☐ side-swiped on the passenger's side

You were the ☐ restrained ☐ unrestrained ☐ Driver ☐ Passenger in the ☐ front seat ☐ rear seat

Was there an air bag? ☐ Yes ☐ No Did it deploy? ☐ Yes ☐ No Did you lose consciousness? ☐ Yes ☐ No

Was anyone else injured in the accident? ☐ Yes ☐ No

Is there a Lawyer involved in your case? ☐ Yes ☐ No Name: _____

*****Please complete the following section ONLY IF you were injured on the job*****

☐ **Work-Related injury** involving ☐ lifting ☐ a fall ☐ other: _____

Date of injury? _____ When did you first notice pain? _____

Are you currently working? ☐ Yes ☐ No ☐ Full Duty ☐ Light Duty ☐ Date last worked: _____

If yes, then how many hours each day? _____ What are your job responsibilities? _____

Is your supervisor sympathetic to your needs? ☐ Yes ☐ No Explain: _____

If you are not working, how long have you been out of work? _____ Have you tried to return to work? ☐ Yes ☐ No

When? _____ Why did you stop? _____

If you are out of work, do want to return to work? ☐ Yes ☐ No

Please list your work history (include type of job, how long your worked and why you left): _____

Is there a Rehabilitation Nurse, Counselor or Vocational Specialist working with you? ☐ Yes ☐ No Who? _____

Is there a Lawyer involved in your case? ☐ Yes ☐ No Name: _____

Have you applied for social security disability? ☐ Yes ☐ No

Are you receiving social security benefits? ☐ Yes ☐ No

Please list any other previous injuries (include fractures, head injuries, car accidents, falls, etc…):

Type	Date	Physician

Please list all other physicians who have treated you and describe what they have recommended:

Physician:	Treatment Recommended:

DIAGNOSTIC TESTS

Please check all diagnostics tests that have been performed and indicate when and where they were done.

Test Performed:	Date	Location
☐ Plain X-ray		
☐ Cat-Scan		
☐ MRI		
☐ EMG/Nerve Conduction Studies		
☐ Myelogram		
☐ Discogram		

MEDICATION HISTORY – Please list all current medications (including over the counter medications)

Please feel free to attach additional sheets if necessary.

Medication	Indication	Dose	Prescribing Physician

ALLERGIES

Please list drug allergies, type of reaction and onset date if known:

☐ **NO KNOWN DRUG ALLERGIES**

☐ Iodine allergy

☐ Contrast Dye (IVP) allergy

☐ Latex allergy

Any Severe Allergic Reactions (Anaphylaxis) to anything? ☐ Yes ☐ No If yes, to what, type of reaction and onset date.

PREVIOUS TREATMENT

☐ Physical Therapy

☐ TENS unit

☐ Chiropractic

☐ Psychological support Name:

☐ Work Hardening

☐ Injections: ☐ Trigger Point

☐ Acupuncture

☐ Other:

Pain Clinics ☐ Yes ☐ No Where: When?

PAST MEDICAL HISTORY

☐ **No significant Past Medical History**

☐ Alzheimer's disease
☐ Anemia
☐ Aneurysm
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial fibrillation
☐ Back disorder
☐ Bladder incontinence (chronic)
☐ BPH (prostate enlargement)
☐ Bursitis hip region
☐ CANCER-Type:
☐ Cardiac pacemaker
☐ Carpal tunnel syndrome
☐ Cerebral palsy
☐ Cervicalgia (neck pain)

☐ COPD (emphysema
☐ Dementia
☐ Depression
☐ Developmental delay
☐ Diabetes
☐ DVT (blood clot)
☐ Gallbladder disorder
☐ Gastric ulcer
☐ Gout
☐ Head injury or concussion
☐ Headache
☐ Heart disease (coronary artery disease)
☐ Heart failure
☐ Hepatitis
☐ Hernia
☐ High cholesterol

☐ Hip injury or pain
☐ HIV/AIDS Disease
☐ Hypertension (High blood Pressure)
☐ Intestinal disorder
☐ Irritable bowel syndrome
☐ Kidney stones
☐ Lupus
☐ Migraine
☐ Multiple sclerosis
☐ Muscle spasm
☐ Neck Disorder
☐ Osteoporosis
☐ Pain in joint, knee
☐ Pain in joint, shoulder
☐ Paraplegia
☐ Parkinson's disease

☐ Peripheral neuropathy
☐ Peripheral vascular disease
☐ Psoriasis
☐ Quadriplegia
☐ Rheumatoid arthritis
☐ RSD (complex regional pain syndrome)
☐ Sacroiliitis
☐ Scoliosis, idiopathic
☐ Seizure disorder
☐ Sleep Apnea
☐ Spinal cord injury
☐ Stroke (CVA),
☐ Thyroid abnormality
☐ TMJ pain
☐ Tremor

Other Past Medical History:

SURGICAL HISTORY

☐ **No Pertinent Past Surgical History**

Surgery	Date	Surgery	Date	Surgery	Date
☐ Amputation		☐ Carpal tunnel release		☐ Knee Surgery	
☐ Aneurysm repair (thoracic or abdominal)		☐ D & C		☐ ORIF (surgical fixation of fracture)	
		☐ Elbow surgery			
☐ Angioplasty		☐ Eye surgery		☐ Prostate surgery	
☐ Appendix removal (Appendectomy)		☐ Foot/ankle surgery		☐ Shoulder surgery	
		☐ Gallbladder removal (cholecystectomy)		☐ Spine surgery-cervical	
☐ Bilateral tubal ligation (tubes tied)				☐ Spine surgery-lumbar	
		☐ Gastric bypass		☐ Spine surgery-thoracic	
☐ Bladder surgery		☐ Heart valve replacement		☐ Stent -artery in leg, abdomen or pelvis	
☐ Bowel surgery		☐ Hip replacement			
☐ Breast biopsy		☐ Hysterectomy		☐ Stent-heart (cardiac)	
☐ Breast Augmentation		☐ Implanted pacemaker		☐ Thyroid surgery	
☐ CABG (cardiac bypass)		☐ Kidney surgery		☐ TMJ Repair	
		☐ Knee replacement		☐ Trigger finger release	

Other Pertinent Past Surgical History: _____

FAMILY MEDICAL HISTORY

Condition:	Relative	Age	Condition	Relative	Age
☐ Family History Unknown			☐ No Significant Family History		
☐ Arthritis			☐ Spine disorders		
☐ Cancer: TYPE:			☐ Stroke		
☐ Diabetes			**Other Family Medical Problems:**		
☐ Heart disease (coronary artery disease)					
☐ High blood pressure (Hypertension)					
☐ Migraine					

SOCIAL HISTORY

☐ Able to care for self
☐ Able to drive
☐ Alcohol more than 15 drinks/week
☐ Alcohol: Occasional use
☐ Alcohol: Denies use
☐ Climbs stairs daily
☐ Has children
☐ Marital status: Divorced/separated
☐ Marital status: Married
☐ Marital status: Single
☐ Marital status: Widow/widower
☐ Regular exercise

☐ Smoking: admits to smoking
☐ Smoking: Denies smoking
☐ Student
☐ Substance abuse in past (including alcohol)
☐ Substance Abuse : Use of illegal drugs in the last year
☐ Work status: Disabled
☐ Work status: Retired
☐ Work status: Works outside the home

☐ Smoking: Previous Smoker
Date Quit:_____

Occupation: _____

Other important social issues: _____

_____

_____