

WESTERN NEUROSURGICAL CLINIC
MEDICAL EVALUATION QUESTIONNAIRE

Date: _____

IDENTIFICATION:

Name: _____ Date of Birth _____

Age: _____ Social Security No.: _____ Driver's Lic.# _____

Occupation: _____ Employer: _____

WE REQUEST ALL PATIENTS TO FILL OUT THE QUESTIONNAIRE AS COMPLETELY AS POSSIBLE.

Weight: _____ lbs.

Height: _____ ' _____ "

*Is this a work related injury? ___ yes. ___ No.
If yes, do you have an ongoing claim with a worker's compensation insurance company?
Or do you plan on filing a claim? ___ yes. ___ no.*

*Is this an automobile related injury? ___ yes. ___ No.
If yes, have you filed a claim with an auto insurance company? ___ yes. ___ no.
If yes, please give us details: _____*

If you have filed any of the above claims, it is your responsibility to inform us now. If you withhold this information from us, our office will not be responsible for any legal repercussions.

Are you ___ right-handed ___ left-handed? Are you still working? ___ yes ___ no.

SYMPTOMS: *Please describe in your own words how your injury happened. Please describe how and when the symptoms first started (must be filled out).*

Have you had any previous trouble or injury involving this part of your body? If so, please explain: _____

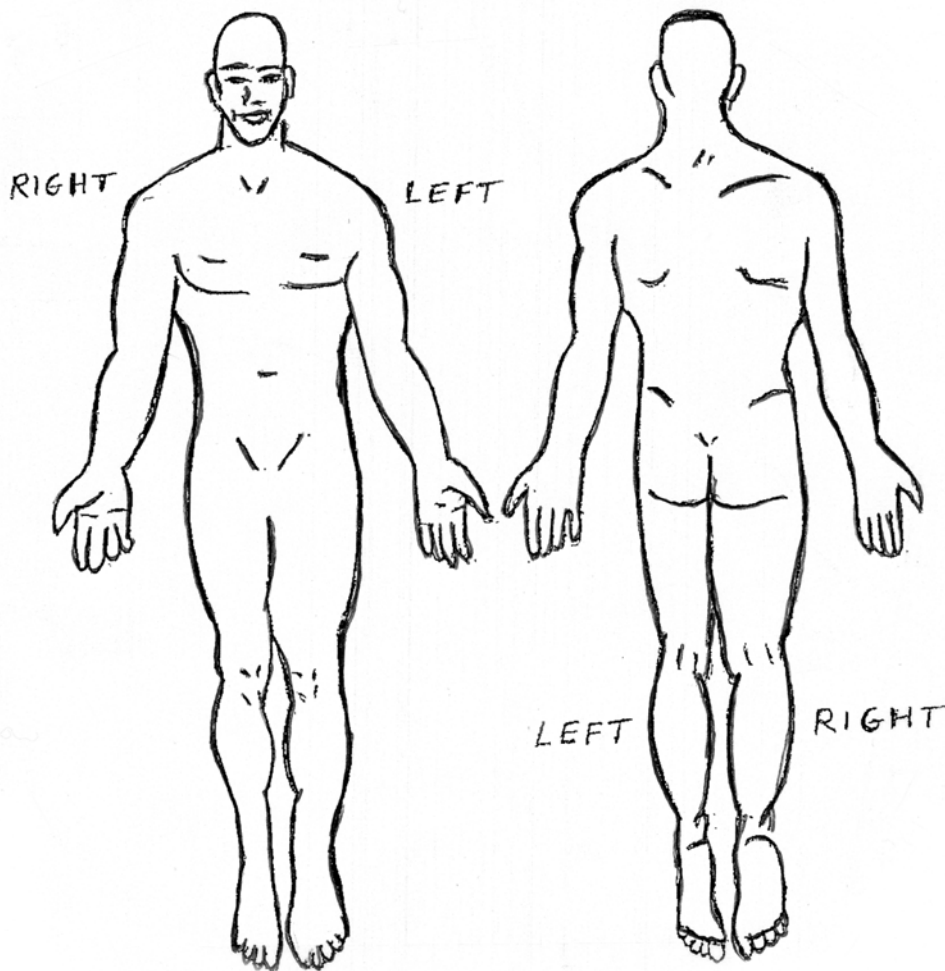
PAIN LOCATION DRAWING

If you have any of the following symptoms, please indicate by placing the letters that describe your symptoms on the models below:

P: = Pain

W: = Weakness

N: = Numbness or Tingling



How long have you had your current symptoms?

____ 0 - 6 months ____ 6 - 12 months ____ 12 - 24 months
 ____ 24 - 36 months ____ longer than 36 months

Where is most of your pain located? Circle the best answer.

1. neck 2. arms 3. back 4. legs 5. other

If you answered "other", please explain: _____

How severe is your pain? Circle the number on the scale of 0 - 10 that best describes your pain in each area. (0 = no pain; 10 = severe)

Neck: 0 1 2 3 4 5 6 7 8 9 10
 Arm(s): 0 1 2 3 4 5 6 7 8 9 10
 Back: 0 1 2 3 4 5 6 7 8 9 10
 Leg(s): 0 1 2 3 4 5 6 7 8 9 10

What time of day is your pain worst? ____ Early day ____ Late day ____ Night

In the past 6 months, has your pain ____ lessened ____ worsened ____ unchanged?

How often are you in pain? (check the correct answer.)

____ Occasional = approximately 25% of the time.
 ____ Intermittent = approximately 50% of the time.
 ____ Frequent = approximately 75% of the time.
 ____ Constant = 90 - 100% of the time.

What activities relieve your pain? What makes it worse? Please mark the correct box for each activity shown.

	<u>Makes pain worse</u>	<u>Relieves the pain</u>
a. Sitting-----		
b. Standing-----		
c. Walking-----		
d. Running-----		
e. Athletic activity-----		
f. Driving-----		
g. Coughing or sneezing-----		
h. Warm baths or showers-----		
i. Lying on you back -----		
j. Lying with your legs up-----		
k. Lying on your side -----		
l. Lifting objects -----		
m. Bicycle riding -----		

How long can you do each of the following without pain?

Stand ___ 5 minutes ___ 5 to 30 minutes ___ longer than 30 minutes

Sit ___ 5 minutes ___ 5 to 30 minutes ___ longer than 30 minutes

walk ___ 1 block ___ half mile ___ 1 mile or more

If you rest for 15 minutes, can you continue walking? ___ yes ___ no.

How much can you lift without pain?

___ 5 lbs ___ 25 lbs ___ 50 lbs or more.

MEDICATIONS:

Are you currently taking any prescription medications? ___ yes ___ no.

If answered "yes", please complete the following:

<u>Name</u>	<u>Strength</u>	<u>How Often</u>
Prescription pain: _____		
Medication		

Anti-inflammatory		
Medication:		

Muscle Relaxant: _____

Medications for _____
other conditions:

Name of Physician who prescribed the above medications: Dr. _____

Physician's Phone Number: _____

Non - prescription pain medicine: ___ Aspirin ___ Tylenol Other _____

How Often? _____

CURRENT TREATING PHYSICIAN:

Do you currently have a Treating Physician for this medical problem? ___ yes ___ no.

Do you want a report on your visit sent to this physician? ___ yes ___ no

If you answered yes, please provide the following information: (We will not be able to do the report without your physician's COMPLETE ADDRESS)

a. Doctor's Name: _____

b. Address: _____

c. Telephone No.: _____

CURRENT TREATMENT

Please list, with dates, the names of all the doctors you have seen for **THIS** injury. What kinds of treatment did each of these doctors provide? (Use the back of this page if necessary).

<u>Date</u>	<u>Doctor's Name</u>	<u>Kind Of Treatment Provided</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CONSERVATIVE TREATMENT:

Have you had physical therapy for your current problem? ____ yes ____ No

If you have answered yes, when did you start? _____

How Often? _____ When did you stop? _____

Did you benefit from physical therapy: ____ yes ____ no.

Explain: _____

At any time since your injury, have you had 4 to 5 days of bed rest? ____yes____ No

If yes, when and for how long? _____

Have you had traction therapy? ____ yes ____ No

Have you had epidural steroid injection? ____ yes. ____ no.

If so, how many? _____. When? _____

Did you benefit from epidural injections? _____

Do you use any of the following to help you walk?

_____ Cane _____ Crutches _____ Walker

FAMILY HISTORY

Age

Health

Father

Mother

Brothers

Sisters

Other significant diseases in family:

Cancer Diabetes High Blood Pressure Heart Disease Ulcers

Other: _____

SOCIAL HISTORY (please circle one within ().

1. Marital Status (Single - Married - Widow(er) - Divorced)

Spouse's occupation: _____

If you have children, how old are they? _____

2. Education : (High School - College - Post-Grad - Trade/Tech.)

3. How often do you drink alcoholic beverages? (Never - Occasionally - Frequently).

4. Do you currently smoke ? (Y N) If yes, ___Pack(s)/day. How long? _____

Did you previously smoke?(Y N)

5. Have you used/Do you use any recreational drugs? (Y N). If yes, what kind? _____

6. What were your main leisure activities before your injury?

What are your main activities since your injury? _____

7. Is there a lawsuit planned relating to your medical problem/injury? (Y N)

If yes, against whom? _____ Attorney: _____

REVIEW OF SYSTEMS: (Circle Y or N)

1. Has your sleep pattern changed recently? (Y N).

2. Are you allergic to medications, anesthetics, or x-ray dyes (Y N). If yes, what kind? _____

3. Are you depressed because of your injury? (Y N).

4. Have you had any recent weight gain? (Y N). How much? _____

5. Have you been in good general health for most of your life? (Y N).

6. Do you currently have any of these symptoms? Please circle Y or N. If the symptoms are not current, but you have experienced these symptoms in the past, please write "P" next to the question.

<u>Skin:</u>			<u>Cardiovascular:</u>		
Hives	N	Y	Chest pain or Angina	N	Y
Eczema	N	Y	Shortness of Breath when walking		
Frequent boils	N	Y	or lying down	N	Y
Skin infections	N	Y	Difficulty walking 2 blocks due		
Abnormal pigmentation	N	Y	to heart problems	N	Y
Jaundice (Yellowing)	N	Y	Heart trouble or prior heart attack	N	Y
			(Cardiovascular continued)		
<u>Heent:</u>			High Blood Pressure	N	Y
Do you wear glasses?	N	Y	Swelling of hands, feet, or ankles	N	Y
Eye injury or disease	N	Y	Awakening at night with		
Seeing double	N	Y	smothering feeling	N	Y
Glaucoma	N	Y	Heart murmur	N	Y
Itchy eyes and nose	N	Y	<u>Neck</u>		
Sneezing/runny nose	N	Y	Stiffness	N	Y
Nosebleeds	N	Y	Thyroid trouble	N	Y
Sinus trouble	N	Y	Enlarged glands	N	Y
Ear infections	N	Y	<u>Respiratory</u>		
Hearing loss	N	Y	URI (cold) now	N	Y
Dizziness or loss of consciousness	N	Y	Spitting up blood	N	Y
<u>Locomotor/Musculoskeletal:</u>			Chronic cough	N	Y
Varicose veins	N	Y	Asthma/Wheezing	N	Y
Muscle or joint weakness	N	Y	Difficulty breathing	N	Y
Difficulty walking	N	Y	Pleurisy or Pneumonia	N	Y
Pain in calves or buttocks			Other lung trouble	N	Y
on walking, relieved			If yes, explain _____		
by rest	N	Y	<u>Neuro-Psychiatric:</u>		
<u>Gastrointestinal</u>			Have you ever had Psychiatric		
Stomach Ulcer	N	Y	Care?	N	Y
Vomiting Blood or food	N	Y	Do you have, or have you had,		
Gallbladder disease	N	Y	fainting spells?	N	Y
Liver trouble	N	Y	Convulsions	N	Y
Hepatitis	N	Y	Paralysis	N	Y
Pain or bleeding with bowel movements	N	Y	<u>Hematological:</u>		
Black stools	N	Y	Cuts slow to heal?	N	Y
Hemorrhoids(piles)	N	Y	Blood disease	N	Y
Recent change in bowel habits	N	Y	Phlebitis	N	Y
Frequent diarrhea	N	Y	Excessive bleeding after tooth		
Heartburn/Indigestion	N	Y	extraction or surgery	N	Y
Difficulty swallowing	N	Y	<u>Abnormal</u> bruising or bleeding	N	Y
Abdominal pain	N	Y	<u>Endocrine:</u>		
			Hormone therapy	N	Y
			Diabetes	N	Y
			Change in hat or glove size	N	Y
			Have you become colder than		
			before or has skin become dryer?	N	Y

Genitourinary:

Loss of urine N Y

Frequent urination N Y

Nighttime urinating N Y

Painful urination N Y

Blood in urine N Y

Kidney Disease N Y

Kidney Stones N Y

Gynecological:(women only)

Age periods started _____

How long do periods last? _____ days

Date of your last period ____/____/____

Number of pregnancies: _____

Number of miscarriages _____

Are you pregnant now? _____

Date of last cancer smear and results: _____

My signature signifies that I have read, answered, and understand all of the above information.

Patient's Name: _____

Patient's signature: _____

Date _____

THANK YOU!

Your patience in fully and accurately completing this form is appreciated. The information contained in it will be important in preparing reports for your doctors/ surgery authorization. If you are unsure about the meaning of any of the questions, we will be happy to explain.

FOR OFFICE USE ONLY:

I reviewed and confirmed all of the above information with the patient.

Signature of Physician/Physician Assistant
