STANTON SCHIFFER, M.D.

PATIENT INFORMATION

Patient's Name: _____
Last **First** **Middle**

Home Address: _____

City : _____ **State :** _____ **Zip:** _____

Home Phone : _____ **Cell Phone :** _____

Work Phone # _____ **Fax #** _____

Date of Birth : _____**Age:** _____ **Sex:** _____ **M** _____ **F**

SS# _____ **Married :** _____ **Single:** _____

Driver's License# _____ **E-Mail Address** _____

Employer : _____ **Occupation:** _____

Business Address: _____

Name of Spouse : _____ **Spouse's Phone #** _____

Emergency Contact : _____ **Relationship :** _____

Emergency Phone/s # _____

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INSURANCE INFORMATION:

Name of Ins. Co.: _____

Phone/s # _____

Address : _____

ID # _____ **Group #** _____

Policy Holder's Name: _____

Reason for this Neurosurgical Consult : Low Back _____ **Neck** _____ **Thoracic** ___ **Other**

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WESTERN NEUROSURGICAL CLINIC
MEDICAL EVALUATION QUESTIONNAIRE

***Date*:_____**

IDENTIFICATION:

Name:_____Date of Birth _____

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

Occupation: _____Employer:_____

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

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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.

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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:_____

_____

_____

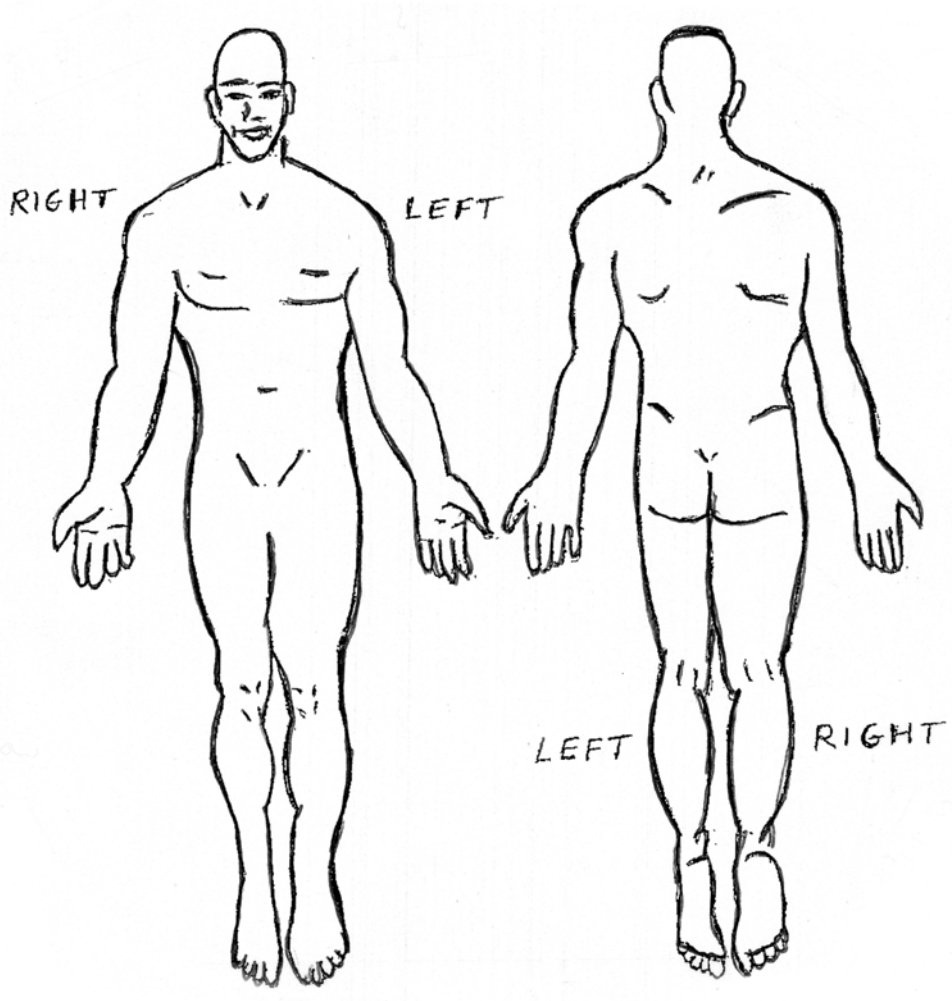
_____

_____

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 anwer.
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.

	Makes pain worse	***Relieves the pain***
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:

	Name	***Strength***	***How Often***
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).

Date	***Doctor's Name***	***Kind Of Treatment Provided***

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

DIAGNOSTIC STUDIES

Give the dates of any of the following diagnostic studies or treatments you have had for your current injury.

	Date/s		***Date/s***
___ ***MRI***	_____	____ ***X-rays***	_____
___***CT Scan***	_____	____ ***Myelogram***	_____
___***EMG/NCT***	_____	____***Other***	_____

***PAST MEDICAL HISTORY*:**
Did you ever have any unusual childhood illnesses? ___ Yes ___ No.
Did you ever have any childhood injuries? ___ Yes ___ No.
Did you have any adult illnesses in the past 6 months?___Yes ___ No.
If you have answered "yes" to the above, please explain:

_____
_____

Surgeries: (List and give year) ***Year***

_____

_____

Hospitalizations other than for surgery: ***Year***

_____

_____

Fractures ***Date***

_____

_____

Accidental Injuries: (List previous injuries and give year, part of the body that was injured, and what were you doing when the injury occurred. Include sports injuries, and injuries associated with motor vehicle accidents).

_____

_____

_____

_____

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

<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			***Spitting up blood***	***N***	***Y***
consciousness	***N***	***Y***	***Chronic cough***	***N***	***Y***
<u>Locomotor/Musculoskeletal</u>:			***Asthma/Wheezing***	***N***	***Y***
Varicose veins	***N***	***Y***	***Difficulty breathing***	***N***	***Y***
Muscle or joint weakness	***N***	***Y***	***Pleurisy or Pneumonia***	***N***	***Y***
Difficulty walking	***N***	***Y***	***Other lung trouble***	***N***	***Y***
Pain in calves or buttocks			***If yes, explain_____***		
on walking, relieved			***<u>Neuro-Psychiatric:</u>***		
by rest	***N***	***Y***	***Have you ever had Psychiatric***		
<u>Gastrointestinal</u>			***Care?***	***N***	***Y***
Stomach Ulcer	***N***	***Y***	***Do you have, or have you had,***		
Vomiting Blood or food	***N***	***Y***	***fainting spells?***	***N***	***Y***
Gallbladder disease	***N***	***Y***	***Convulsions***	***N***	***Y***
Liver trouble	***N***	***Y***	***Paralysis***	***N***	***Y***
Hepatitis	***N***	***Y***	***<u>Hematological:</u>***		
Pain or bleeding with			***Cuts slow to heal?***	***N***	***Y***
bowel movements	***N***	***Y***	***Blood disease***	***N***	***Y***
Black stools	***N***	***Y***	***Phlebitis***	***N***	***Y***
Hemorrhoids(piles)	***N***	***Y***	***Excessive bleeding after tooth***		
Recent change in bowel			***extraction or surgery***	***N***	***Y***
habits	***N***	***Y***	***<u>Abnormal</u> bruising or bleeding***	***N***	***Y***
Frequent diarrhea	***N***	***Y***	***<u>Endocrine:</u>***		
Heartburn/Indigestion	***N***	***Y***	***Hormone therapy***	***N***	***Y***
Difficulty swallowing	***N***	***Y***	***Diabetes***	***N***	***Y***
Abdominal pain	***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*	***Gynecological:(women only)***
Nighttime urinating	*N*	*Y*	*Age periods started _____*
Painful urination	*N*	*Y*	*How long do periods last?_____ days*
Blood in urine	*N*	*Y*	*Date of your last period _____/_____/_____*
			Number of pregnancies:_____
Kidney Disease	*N*	*Y*	*Number of miscarriages _____*
Kidney Stones	*N*	*Y*	*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_____

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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.

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FOR OFFICE USE ONLY:

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

_____

Signature of Physician/Physician Assistant

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