PATIENT HEALTH HISTORY QUESTIONNAIRE

In preparation for your appointment please bring:

- This form completed and signed
- All pertinent medical records
- Results of your last EKG and/or other tests
- X-ray/CT/MRI on CD/films, not just reports
- Insurance card

UFHealth
COMPREHENSIVE SPINE CENTER

PATIENT INFORMATION:

Last Name	First Name	Middle Initial
Date of Birth _____/_____/_____	Age	Gender ☐ Female ☐ Male ☐ Other

PRIMARY CARE PROVIDER:

Name of Doctor	Phone Number	Address
Seeing a specialist? If so, who?	Phone Number	Address

REASON FOR VISIT:

Today's Date: _____/_____/_____

What brings you in today?

Answer the following questions. Fill in box for "Yes" like this:

☒ Yes ☐ No

ALLERGIES:

Are you allergic to anything?

Medicines*	☐ Yes	☐ No
X-RAY dye	☐ Yes	☐ No
Iodine	☐ Yes	☐ No
Other*	☐ Yes	☐ No

*List all allergies including medicines or other:

_____

_____

MEDICATIONS:

Are you taking any of these now?

Aspirin	☐ Yes	☐ No
Anti-Inflammatory	☐ Yes	☐ No
Plavix	☐ Yes	☐ No
Fish Oil	☐ Yes	☐ No
Coumadin (Warfarin)	☐ Yes	☐ No
Other*	☐ Yes	☐ No

*List all medicines you are currently taking:

Vitamins, Supplements, or Over the Counter

Name:	How much?	How many times?
Example: Vitamin C	500 mg (1 tablet)	1 per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL HISTORY:

Have you ever had or currently have one of these conditions?

Allergies	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Blood transfusion	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Congestive Heart Failure	☐ Yes	☐ No
Nerve/Muscle Disease	☐ Yes	☐ No
Lung disease	☐ Yes	☐ No
Meningitis	☐ Yes	☐ No
Depression	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Diabetes Mellitus	☐ Yes	☐ No
Blood Clot	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Acid Reflux	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Gout	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Sickle Cell Anemia	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Substance Abuse	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
Anesthetic Complications	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No

Other condition(s) not listed _____

HISTORY OF SURGERY:

Have you ever had any of these surgeries?

Appendix	☐ Yes	☐ No
Brain Surgery	☐ Yes	☐ No
Breast Surgery	☐ Yes	☐ No
Open Heart/Bypass	☐ Yes	☐ No
Gall Bladder	☐ Yes	☐ No
Colon Surgery	☐ Yes	☐ No
Fracture Surgery	☐ Yes	☐ No
Hernia Repair	☐ Yes	☐ No
C-Section	☐ Yes	☐ No
Eye Surgery	☐ Yes	☐ No
Hysterectomy	☐ Yes	☐ No
Joint Replacement	☐ Yes	☐ No
Small Intestine Surgery	☐ Yes	☐ No
Spine Surgery	☐ Yes	☐ No
Tubes Tied	☐ Yes	☐ No
Heart Valve Replacement	☐ Yes	☐ No
Cosmetic Surgery	☐ Yes	☐ No
Orthopedic Surgery	☐ Yes	☐ No

Other surgery (-ies) not listed _____

FAMILY MEDICAL HISTORY:

Does anyone in your family have a medical condition or disease?

Family Member:	Disease:
Example: Mother	*Breast Cancer*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY:

Marital status:

☐ Single ☐ Married
☐ Separated ☐ Divorced
☐ Widowed

Who lives at home with you? _____

_____

_____

Is your family support…

☐ Strong ☐ Average ☐ Minimal ☐ None

What do you enjoy doing? _____

_____

_____

What causes you stress? _____

_____

_____

Employment history:

Are you employed?

☐ Yes ☐ No

What is your occupation:

_____

#Hours/Day _____ #Days/Week: _____

If no, when did you last work?

_____

What was your most recent job?

_____

Are you receiving disability benefits right now?

☐ Yes ☐ No

If yes, since when?

_____

Are you involved with Worker's Compensation?

☐ Yes ☐ No

If yes, is there litigation pending?

☐ Yes ☐ No

Education:

Please check the box of the highest level of education that you have completed:

- ☐ Grade school
- ☐ High school
- ☐ Junior college
- ☐ Some college
- ☐ Graduate college
- ☐ Graduate/professional school

Substance Use:

Do you smoke cigarettes? ☐ Yes ☐ No

If yes, how many packs per day? _____

How many years? _____

If former smoker, when did you start? _____

How many packs per day? _____

How many years? _____

Do you use alcohol? ☐ Yes ☐ No

How often? _____

How many years? _____

Do you use illegal drugs? ☐ Yes ☐ No

How often? _____

How many years? _____

Have you ever had a problem with alcohol, illicit drugs, or prescription meds?

If yes, please explain:

_____

_____

Review of Systems:

Do you currently have, or had, a problem with:

Constitutional:

- ☐ Fever
- ☐ Weight loss
- ☐ Excessive Fatigue

Eyes:

- ☐ Wear glasses
- ☐ Infections
- ☐ Injuries
- ☐ Glaucoma
- ☐ Cataracts

Head/Ears/Nose/Throat:

- ☐ Wears hearing aid(s)
- ☐ Hearing loss
- ☐ Ear pain
- ☐ Ear infections
- ☐ Ringing in ears (If yes, circle: LEFT- RIGHT- BOTH)
- ☐ Nose bleeds
- ☐ Nasal congestion
- ☐ Nasal drainage
- ☐ Inability to smell
- ☐ Sinus problems
- ☐ Balance disturbance (Vertigo, Spinning, etc.)

Cardiovascular:

- ☐ Chest pain or angina
- ☐ High blood pressure
- ☐ Irregular pulse
- ☐ Heart murmur
- ☐ High cholesterol
- ☐ Swelling in hands and feet
- ☐ Leg pain while walking

Respiratory:

- ☐ Asthma
- ☐ Emphysema
- ☐ Shortness of breath
- ☐ Pneumonia
- ☐ Lung cancer
- ☐ Bloody sputum

Gastrointestinal:

- ☐ Nausea
- ☐ Vomiting
- ☐ Blood in your vomit
- ☐ Liver disease
- ☐ Jaundice
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Ulcers or gastritis
- ☐ Colon Cancer

Endocrine:

- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Excessive thirst or urination

Genitourinary:

- ☐ Urinary tract infection
- ☐ Pain urinating
- ☐ Blood in your urine
- ☐ Difficult starting/ stopping stream
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Prostate cancer (male)
- ☐ Uterine or cervical cancer (female)

Musculoskeletal:

- ☐ Broken bones
- ☐ Arm or leg weakness
- ☐ Arm or leg pain
- ☐ Joint or swelling
- ☐ Arthritis

Integumentary:

- ☐ Skin disease
- ☐ Skin cancer
- ☐ Breast pain, tenderness (female)
- ☐ Nipple discharge (female)

Neurological:

- ☐ Fainting spells or “black outs”
- ☐ Seizures
- ☐ Problems with memory
- ☐ Disorientation
- ☐ Difficulty with speech
- ☐ Inability to concentrate
- ☐ Double or blurred vision
- ☐ Weakness in arms and/ or legs
- ☐ Loss of sensation
- ☐ Difficulty with balance

Psychiatric:

- ☐ Anxiety
- ☐ Depression
- ☐ Other psychiatric disorder and / or Treatment:

Hematologic / Lymphatic:

- ☐ Anemia
- ☐ Hemophilia
- ☐ Bleeding tendencies
- ☐ Blood transfusion
- ☐ Persistent swollen glands or lymph nodes
- ☐ Deep venous thrombosis
- ☐ Pulmonary embolus

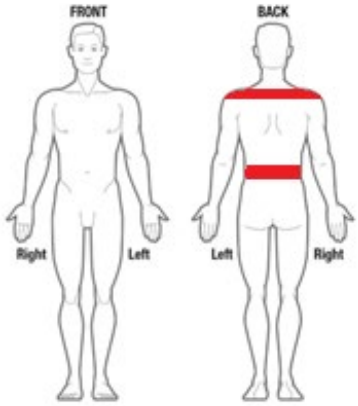
Allergic / Immunologic:

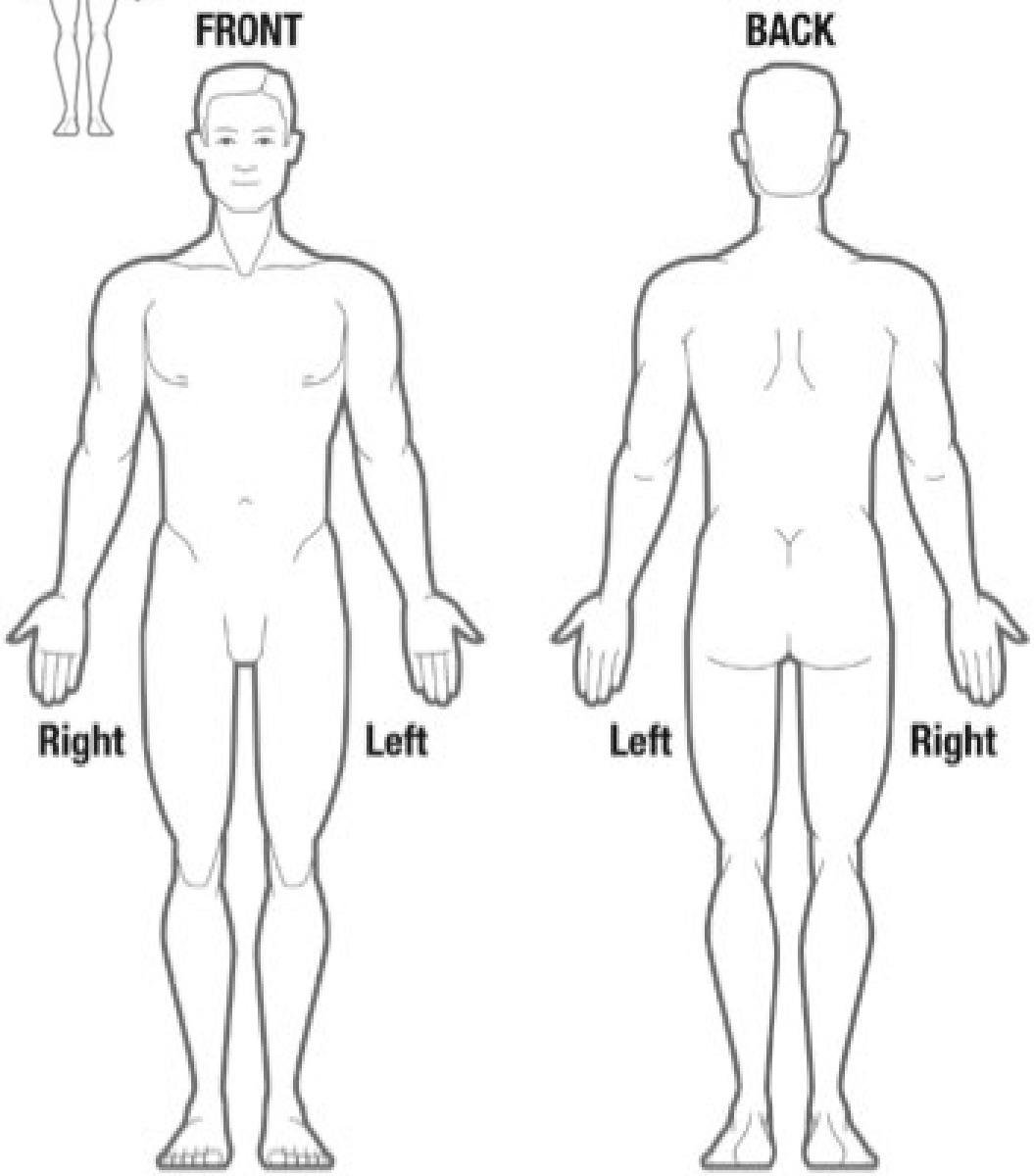
- ☐ Food allergies
- ☐ Inhalant (nasal) allergies
- ☐ Autoimmune disease (Lupus, Rheumatoid Arthritis, etc.)

Current Problem:

Show us where your pain is located by coloring where you feel pain.

Example:



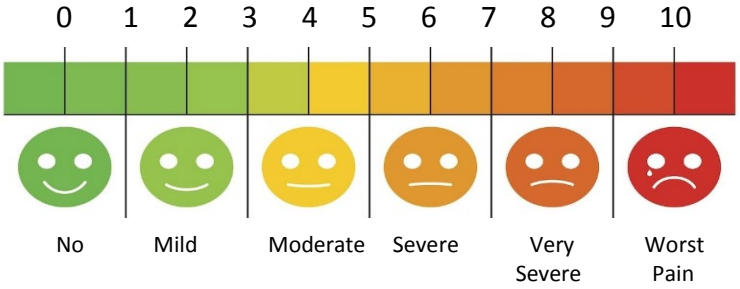


Rate Your Pain:

Circle the box representing your pain (0 being none, and 10 the worst)

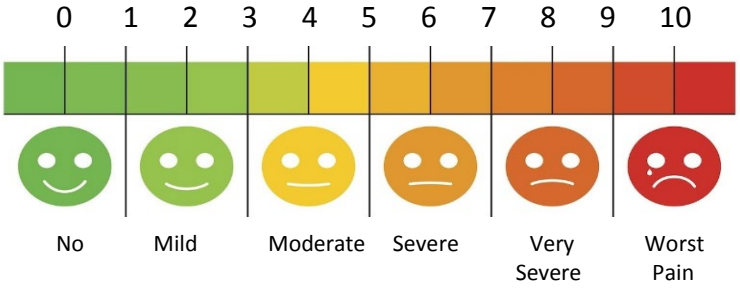
How would you describe your NECK pain?

Most Days:



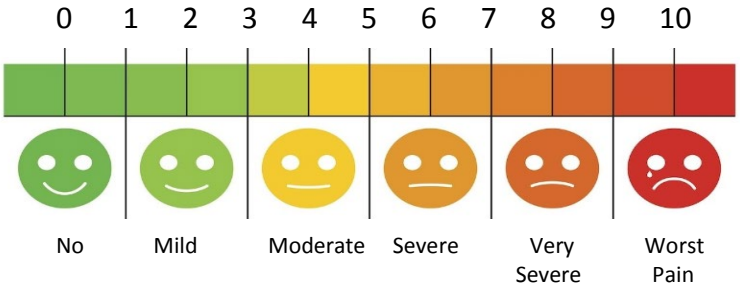
How would you describe your ARM pain?

Most Days:



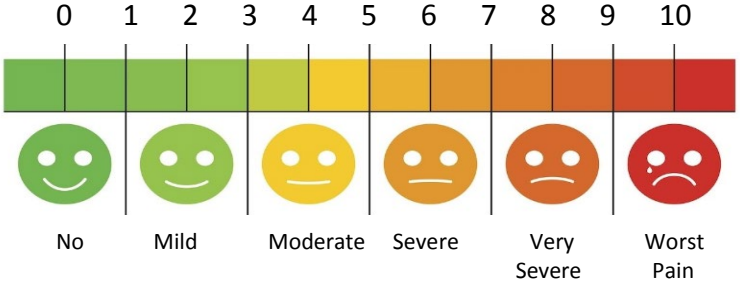
How would you describe your BACK pain?

Most Days:



How would you describe your LEG pain?

Most Days:



Which words describe the QUALITY of your pain?

- ☐ Throbbing
- ☐ Cold/freezing
- ☐ Stabbing
- ☐ Cramping
- ☐ Hot/burning
- ☐ Itching
- ☐ Heavy/pressure
- ☐ Electric-shock
- ☐ Numbness
- ☐ Tingling/pins & needles
- ☐ Shooting

Please check all ACTIVITIES that make your pain BETTER:

- ☐ Rest
- ☐ Bending
- ☐ Sex
- ☐ Touch
- ☐ Lifting
- ☐ Warm Compresses
- ☐ Sitting
- ☐ Walking
- ☐ Cold Compresses
- ☐ Standing
- ☐ Light exercise
- ☐ Relaxation techniques
- ☐ Other: _____

Please check all ACTIVITIES that make your pain WORSE:

- ☐ Rest
- ☐ Bending
- ☐ Sex
- ☐ Touch
- ☐ Lifting
- ☐ Warm Compresses
- ☐ Sitting
- ☐ Walking
- ☐ Cold Compresses
- ☐ Standing
- ☐ Light exercise
- ☐ Relaxation techniques
- ☐ Other: _____

Treatment Options Attempted:

Physical Therapy Attempted:	☐ Yes (last attempted _____; %relief_____)	☐ No
Acupuncture Attempted:	☐ Yes (last attempted _____; % relief_____)	☐ No
Chiropratic Attempted:	☐ Yes (last attempted _____; % relief_____)	☐ No

Other_____

Pain Management Procedures That You Have Had:

		How many?	Dates performed:
☐	Trigger point injections	_____	_____
☐	Medial branch nerve blocks	_____	_____
☐	Radiofrequency nerve ablation or rhizotomy	_____	_____
☐	Epidural steroid injection	_____	_____
☐	Caudal steroid injection	_____	_____
☐	Spinal cord stimulator	_____	_____
☐	Facet joint injection	_____	_____
☐	Stellate ganglion block	_____	_____
☐	Lumbar sympathetic block	_____	_____
☐	Intercostal nerve block	_____	_____
☐	Knee genicular nerve block	_____	_____
☐	Occipital nerve block	_____	_____
☐	Botox injection	_____	_____
☐	Kyphoplasty/vetebroplasty	_____	_____

The information on this form is accurate to the best of my knowledge:

_____

Patient Signature Date

If you have questions or need assistance in completing this form call 352-265-SPNE (7763)

Low Back Disability Questionnaire:

Mark the box that best fits. Pick the choice that MOST CLOSELY describes you with regards to your LOW BACK.

Pain Intensity

- [ ] I can tolerate the pain without having to use painkillers
- [ ] The pain is bad but I can manage without taking painkillers
- [ ] Painkillers give complete relief from pain
- [ ] Painkillers give moderate relief from pain
- [ ] Painkillers give very little relief from pain
- [ ] Painkillers have no effect on the pain and I do not use them

Personal Care (Washing, Dressing, etc.)

- [ ] I can look after myself normally without causing extra pain
- [ ] I can look after myself normally but it causes extra pain
- [ ] It is painful to look after myself and I am slow and careful
- [ ] I need some help but manage most of my personal care
- [ ] I need help every day in most aspects of self-care
- [ ] I do not get dressed, I was with difficulty and stay in bed

Lifting

- [ ] I can lift heavy weights without extra pain
- [ ] I can lift heavy weights but it gives extra pain
- [ ] Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned, for example on a table
- [ ] Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- [ ] I can lift very light weights
- [ ] I cannot lift or carry anything at all

Walking

- [ ] Pain does not prevent me from walking any distance
- [ ] Pain prevents me from walking more than one mile
- [ ] Pain prevents me from walking more than one-half mile
- [ ] Pain prevents me from walking more than one-quarter mile
- [ ] I can only walk using stick or crutches
- [ ] I am in bed most of the time and have to crawl to the toilet

Sitting

- [ ] I can sit in any chair as long as I like
- [ ] I can only sit in my favorite chair as long as I like
- [ ] Pain prevents me from sitting more than one hour
- [ ] Pain prevents me from sitting more than 30 minutes
- [ ] Pain prevents me from sitting more than 10 minutes
- [ ] Pain prevents me from sitting almost all the time

Standing

- [ ] I can stand as long as I want without extra pain
- [ ] I can stand as long as I want but it gives me extra pain
- [ ] Pain prevents me from standing more than 1 hour
- [ ] Pain prevents me from standing more than 30 minutes
- [ ] Pain prevents me from standing more than 10 minutes
- [ ] Pain prevents me from standing at all

Sleeping

- [ ] Pain does not prevent me from sleeping well
- [ ] I can sleep well only by using tablets
- [ ] Even when I take tablets I have less than 6 hours of sleep
- [ ] Even when I take tablets I have less than 4 hours of sleep
- [ ] Even when I take tablets I have less than 2 hours of sleep
- [ ] Pain prevents me from sleeping at all

Social Life

- [ ] My social life is normal and gives me no extra pain
- [ ] My social life is normal but increases the degree of pain
- [ ] Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g. dancing)
- [ ] Pain has restricted my social life and I do not go out as often
- [ ] Pain has restricted my social life to my home
- [ ] I have no social life because of pain

Traveling

- [ ] I can travel anywhere without extra pain
- [ ] I can travel anywhere but it gives me extra pain
- [ ] Pain is bad but I can manage journeys over 2 hours
- [ ] Pain is bad but I can manage journeys less than 1 hour
- [ ] Pain restricts me t short necessary journeys under 30 minutes
- [ ] Pain prevents me from traveling except to the doctor or hospital

Changing Degree of Pain

- [ ] My pain is rapidly getting better
- [ ] My pain fluctuates but overall is definitely getting better
- [ ] My pain seems to be getting better but improvement is slow at the present
- [ ] My pain is neither getting better nor worse
- [ ] My pain is gradually worsening
- [ ] My pain is rapidly worsening

Neck Disability Index:

Mark the box that best fits. Pick the choice that **MOST CLOSELY** describes you with regards to your **NECK**.

Pain Intensity

	I have no pain at the moment
	The pain is very mild at the moment
	The pain is moderate at the moment
	The pain is fairly severe at the moment
	The pain is very severe at the moment
	The pain is worst imaginable at the moment

Personal Care (Washing, Dressing, etc.)

	I can look after myself normally without causing extra pain
	I can look after myself normally but it causes extra pain
	It is painful to look after myself and I am slow and careful
	I need some help but manage most of my personal care
	I need help every day in most aspects of self-care
	I do not get dressed, I was with difficulty and stay in bed

Lifting

	I can lift heavy weights without extra pain
	I can lift heavy weights but it gives extra pain
	Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned, for example on a table
	Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
	I can lift very light weights
	I cannot lift or carry anything at all

Reading

- [ ] I can read as much as I want to with no pain in my neck
- [ ] I can read as much as I want to with slight pain in my neck
- [ ] I can read as much as I want with moderate pain
- [ ] I can't read as much as I want because of moderate pain in my neck
- [ ] I can hardly read at all because of severe pain in my neck
- [ ] I cannot read at all

Headaches

- [ ] I have no headaches at all
- [ ] I have slight headaches which come infrequently
- [ ] I have slight headaches which come frequently
- [ ] I have moderate headaches with come infrequently
- [ ] I have severe headaches which come frequently
- [ ] I have headaches almost all the time

Concentration

- [ ] I can concentrate fully when I want to with no difficulty
- [ ] I can concentrate fully when I want to with slight difficulty
- [ ] I have a fair degree of difficulty in concentrating when I want to
- [ ] I have a lot of difficulty in concentrating when I want to
- [ ] I have a great deal of difficulty in concentrating when I want to
- [ ] I cannot concentrate at all

Work

- [ ] I can do as much work as I want to
- [ ] I can only do my usual work, but no more
- [ ] I can do most of my usual work, but no more
- [ ] I cannot do my usual work
- [ ] I can hardly do any work at all
- [ ] I can't do any work at all

Driving

- [ ] I drive my car without any neck pain
- [ ] I can drive my car as long as I want with slight pain in my neck
- [ ] I can drive my car as long as I want with moderate pain in my neck
- [ ] I can't drive my car as long as I want because of moderate pain in my neck
- [ ] I can hardly drive my car at all because of severe pain in my neck
- [ ] I can't drive my car at all

Sleeping

- [ ] I have no trouble sleeping
- [ ] My sleep is slightly disturbed (less than 1hr. sleepless)
- [ ] My sleep is moderately disturbed (1-2 hrs. sleepless)
- [ ] My sleep is moderately disturbed (2-3 hrs. sleepless)
- [ ] My sleep is greatly disturbed (3-4 hrs. sleepless)
- [ ] My sleep is completely disturbed (5-7 hrs. sleepless)

Recreation

- [ ] I am able to engage in all my recreation activities with no neck pain at all
- [ ] I am able to engage in all my recreation activities with some neck pain
- [ ] I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
- [ ] I am able to engage in a few of my usual recreation activities because of pain in my neck
- [ ] I can hardly do any recreation activities because of pain in my neck
- [ ] I can't do any recreation activities at all