Vanderbilt University Medical Center

Spine Center New Patient Packet

Patient Completed Information
Spine New Patient Packet

Patient Label or Paient Identifiers

Patient Name: _____

Date of Birth: _____

Welcome to Vanderbilt Spine Center.
We ask that you take some time to complete this questionnaire to the best of your knowledge. This questionnaire will allow the doctor to know more about you, your medical condition, your family and your habits. **We ask that you fill out this form in ink prior to your visit and bring it with you on the date of your appointment**. This questionnaire is confidential and will be kept as part of your medical record. If you have any questions about issues of confidentiality, please feel free to contact our office at (615)-875-5100.

History of Present Illness:

1. What is the reason for your visit today? _____
2. How long have you had this problem? _____
3. How severe is the problem?
   Please rate your pain on a scale from 0 to 10 (Circle) (0 1 2 3 4 5 6 7 8 9 10)
4. What type of symptoms are you experiencing? _____
5. How often do your symptoms occur? _____
6. How long do your symptoms last? _____
7. Is there anything that makes the problem worse? _____
8. Does anything make the problem better? _____
9. Have you ever had treatment or surgery for this problem? _____

Previous Treatment: *Please check all treatments you have tried.*

- ☐ Previous surgery
- ☐ Physical therapy
- ☐ Exercise program
- ☐ Brace/wrist splints
- ☐ Chiropractor
- ☐ Anti-inflammatory medications (Motrin, Naproxen, Aspirin)
- ☐ Epidural steroid injection(s)
- ☐ Narcotic pain medication (Lortab, Percocet, Vicodin)
- ☐ Other: _____

These provided relief for: ☐ No relief ☐ 1-4 weeks ☐ 5-8 weeks ☐ 8+ weeks

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Please check all conditions that currently apply to you.

General:
- ☐ Weight loss
- ☐ Weight gain
- ☐ Change in appetite
- ☐ Altered taste or smell
- ☐ Fainting
- ☐ Excessive sleepiness
- ☐ Low blood pressure
- ☐ Unable to sleep
- ☐ Fatigue
- ☐ Leg swelling

Eyes:
- ☐ Cataracts
- ☐ Blurred vision
- ☐ Double vision

Ears, Nose, & Throat:
- ☐ Mouth sores
- ☐ Sinus disease
- ☐ Sore throat
- ☐ Ringing in ears
- ☐ Hearing loss

Cardiovascular:
- ☐ Chest pain
- ☐ Heart murmur
- ☐ Chest pressure
- ☐ Angina

Respiratory:
- ☐ Shortness of breath
- ☐ Trouble breathing
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Chronic cough

Gastrointestinal:
- ☐ Ulcer
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bowel incontinence
- ☐ Hiatal hernia
- ☐ Reflux
- ☐ Rectal bleeding

Genitourinary:
- ☐ Sexual dysfunction
- ☐ Impotence
- ☐ Kidney stones
- ☐ Urinary incontinence
- ☐ Urinary urgency
- ☐ Vaginal bleeding
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Blood in urine

Musculoskeletal:
- ☐ Low back pain
- ☐ Neck pain
- ☐ Joint pain
- ☐ Trouble walking
- ☐ Joint swelling
- ☐ Numbness

Neurological:
- ☐ Headache
- ☐ Seizure
- ☐ Memory loss
- ☐ Loss of consciousness
- ☐ Weakness
- ☐ Falling down
- ☐ Vertigo
- ☐ Concussion

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Trouble concentrating

Hematological:
- ☐ Blood disorder
- ☐ HIV
- ☐ Enlarged lymph nodes
- ☐ Hepatitis
- ☐ Tingling leukemia
- ☐ Sickle cell disease

Past Medical History:
- ☐ GERD/Heartburn
- ☐ Ulcers
- ☐ Colon polyps
- ☐ Hernia
- ☐ Pancreatitis
- ☐ Ulcerative colitis
- ☐ Hypertension
- ☐ Coronary artery disease
- ☐ Congestive heart failure
- ☐ Atrial fibrillation
- ☐ Pacemaker
- ☐ AICD (Defibrillator)
- ☐ COPD
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Elevated cholesterol
- ☐ Stroke
- ☐ Fibromyalgia
- ☐ _____
- ☐ _____
- ☐ _____

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Past Surgical History:

- ☐ Colonoscopy
- ☐ EGD (Upper endoscopy)
- ☐ Ulcer surgery
- ☐ Colon surgery
- ☐ Gallbladder
- ☐ Appendectomy
- ☐ Peripheral nerve stimulator
- ☐ Hemorrhoidectomy
- ☐ Cardiac bypass surgery
- ☐ Heart valve replacement
- ☐ Hysterectomy
- ☐ Ovaries removed
- ☐ Breast cancer surgery
- ☐ Spinal cord stimulator
- ☐ Prostate surgery
- ☐ Tonsillectomy
- ☐ Shoulder surgery
- ☐ Back surgery
- ☐ Neck surgery
- ☐ Hip surgery
- ☐ Knee surgery
- ☐ Weight loss surgery
- ☐ Brain surgery
- ☐ Intrathecal pain pump
- ☐ Other: _____

Family History:

- ☐ Arthritis
- ☐ Heart attack
- ☐ Heart disease
- ☐ Peripheral vascular disease
- ☐ Hypertension
- ☐ Cancer
- ☐ High cholesterol
- ☐ Diabetes Mellitus
- ☐ Stroke

Social History:

Do you drink alcohol? ☐ Yes ☐ No If yes, approximately how many drinks per week? _____
Have you used any illicit drugs in the past 12 months? ☐ Yes ☐ No If yes, please explain: _____
Do you smoke? ☐ Yes ☐ No If yes, how often? ☐ Every day ☐ Some days If yes, how many a day? _____
How soon after you wake do you smoke? _____ Are you interested in quitting? ☐ Yes ☐ Thinking about it ☐ No
What is you occupation? _____
☐ Full time ☐ Part time ☐ Retired ☐ Homemaker ☐ Student ☐ Unemployed ☐ Disabled
Was the injury due to a work-related accident? ☐ Yes ☐ No
Was the illness/injury caused by an automobile accident? ☐ Yes ☐ No
Was another party responsible for the accident? ☐ Yes ☐ No
Is there any litigation involved? ☐ Yes ☐ No If yes, please explain: _____

Medications: Please list all medications and dosage you are *currently* taking, including over the counter medications. Please also include the length of time you have been taking ***narcotic*** medications.

	Medications	Dosage	Length of time on medication
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Do you take aspirin or any medicines that contain aspirin such as ibuprofen or Motrin? If yes, please specify:

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Pharmacy: Please provide the name and phone number of your ***Local*** pharmacy so that we may keep this information on file if needed.

Name: _____ Phone: _____

Allergies: Please list any known drug and/or food allergies. ☐ No known drug allergies

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Pain Management:

Are you currently in Pain Management or receiving pain medications from another physician? + ☐ Yes ☐ No

If yes, please list below the name and address this physician:

Name: _____ Address: _____

Phone: _____ Fax: _____

Patient/Legal Representative Print Name: _____

Patient/Legal Representative Signature: _____

Relation: _____ Date: _____ Time: _____