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
## Patient Identifiers

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

### 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

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

### 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
Past Surgical History:
- Colonoscopy
- EGD (Upper endoscopy)
- Uterus surgery
- Colon surgery
- Gallbladder surgery
- Appendectomy
- Peripheral nerve stimulator
- Hemorrhoidectomy
- Other:

Cardiac bypass surgery
Heart valve replacement
Uterus 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

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 your occupation?
- Full time
- Part time
- Retired
- Homemaker
- Student
- Unemployed
- Disabled

Was the illness/injury caused by a work-related accident? □ Yes □ No
Was the injury/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.

<table>
<thead>
<tr>
<th>Medications</th>
<th>Dosage</th>
<th>Length of time on medication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you take aspirin or any medicines that contain aspirin such as ibuprofen or Motrin? If yes, please specify:
**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. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________
6. ____________________________
7. ____________________________
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: ___________