ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

Jeremy S. Smith, M D

New Spine Patient Questionnaire

Name: _____
Age: _____ Hand Dominance: ☐ R ☐ L
Today's Date: _____
☐ Male ☐ Female Pregnant? ☐ Yes ☐ No
Height: _____ Weight: _____
Primary Physician: _____

Primary Dr. Address: _____
_____
Phone Number: _____
Referring Physician: _____
_____
Referring Dr. Address: _____
Phone Number: _____

Chief Complaint: _____
_____
Date of Injury: _____ Time of Injury: _____ Injured at: _____ County of: _____
Did your pain start: ☐gradually ☐suddenly
Are your symptoms now: ☐worse ☐better ☐no change
Degree of current pain: ☐none ☐mild ☐moderate ☐severe
How often do you experience the pain? ☐constant ☐intermittent
What is your pain scale (scale of 1-10; 10 being the worst pain)? _____
Describe your pain ☐aching ☐burning ☐sharp ☐stabbing ☐numbness
☐tingling ☐ _____
What is your back pain to leg pain ration (i.e. 100% back/0%leg)?
☐100/0 ☐90/10 ☐80/20 ☐70/30 ☐60/40 ☐50/50 ☐40/60 ☐30/70 ☐20/80 ☐10/90 ☐0/100
What is your neck pain to arm pain ratio (i.e. 100% neck/0% arm)?
☐100/0 ☐90/10 ☐80/20 ☐70/30 ☐60/40 ☐50/50 ☐40/60 ☐30/70 ☐20/80 ☐10/90 ☐0/100
Where is your pain located? (check all that apply and circle side)
☐neck ☐neck and arm(s) R or L ☐arm(s) R or L
☐back ☐back and arm(s) R or L ☐leg(s) R or L
What aggravates your pain? (standing, sitting, etc.) _____
What relieves your pain? (lying down, sitting, etc.) _____
Do you have numbness? If so, where? _____
Do you have weakness? If so, where? _____
Do you have night pain? _____ Does it wake you up from sleep? _____
Do you have bowel or bladder problems? ☐incontinence ☐constipation ☐hesitancy
Are there any associated symptoms (i.e. nausea, loss of balance, etc.)? _____
_____
What treatments have made your pain better? _____
What treatments have made your pain worse? _____
Have you been in a physical therapy program? ☐yes ☐no Did it help you? ☐yes ☐no
When/where/how often did you go? _____
Are you currently working? ☐no ☐yes what type of work? _____
☐full duty ☐modified duty: _____
Date last worked? _____ Are you able to perform your usual duties? ☐yes ☐no

ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

Jeremy S. Smith, MD

New Spine Patient Medical and Surgical History

Past Medical History

Check all items that apply and describe below if necessary. Otherwise check "none."				NONE
☐ Anesthesia problems:	Describe:			☐
☐ Heart problems:	☐Heart attack	☐Heart failure	☐Stroke	☐
☐ Circulation problems:	☐High blood pressure	☐Poor circulation		☐
☐ Lung problems:	☐Emphysema	☐Asthma ☐Lung Disease ☐Pneumonia ☐Tuberculosis		☐
☐ Diabetes:	☐Date diagnosed:	Controlled with: ☐Insulin ☐Oral meds		☐
☐ Neuropathy:	☐Loss of Feeling:	☐Hands	☐Feet	☐
☐ Endocrine problems:	☐Thyroid	☐Adrenal	☐Pituitary	☐
☐ Blood problems:	☐Anemia	☐Bleeding disorder		☐
☐ Blood clots:	☐Blood clot in leg	☐Blood clot in lung		☐
☐ Cancer:	Type(s):			☐
☐ Stomach problems:	☐Ulcers	☐Hiatal hernia	☐Gastric reflux	☐
☐ Kidney problems:	☐Kidney failure	☐Kidney stones		☐
☐ Liver problems:	☐Hepatitis	☐Cirrhosis		☐
☐ Mental illness:	☐Depression	☐Seizures	☐Alcoholism	☐
☐ Bone/Joint problems:	☐Fractures ☐Gout	☐Osteoarthritis ☐Rheumatoid arthritis	☐Osteoporosis	☐
☐ Immune problems:	☐AIDS	☐HIV	☐Other	☐
☐ Descriptions/Other:				

Past Surgical History ☐ no other surgery ☐ use back of page if more space needed

Type of Surgery	Date	Surgeon/Hospital

Medications (include vitamins and herbs) ☐no medications ☐use back of page if more space needed

Medication/Strength	Dosage	Reason	Medication/Strength	Dosage	Reason

ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

Jeremy S. Smith, M D

New Spine Patient Medical and Surgical History

Allergies ☐no allergies ☐use back of page if more space needed

Allergy	Reaction(s)	Allergy	Reaction(s)

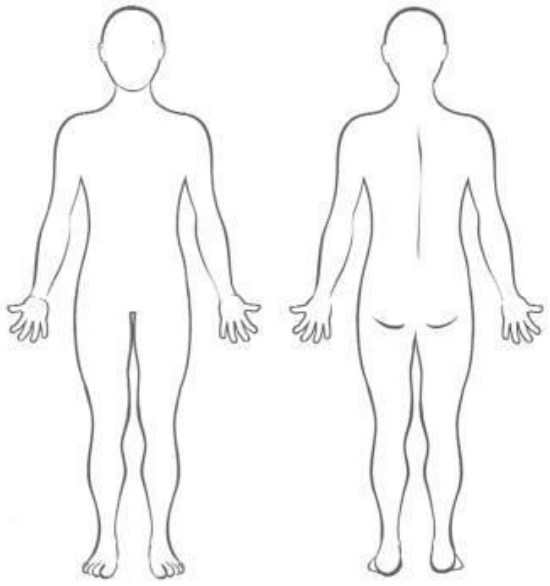
Family History (check all that apply) ☐none apply

☐heart problems ☐lung problems ☐kidney problems ☐stroke ☐arthritis
☐bleeding problems ☐alcoholism ☐seizures ☐spine problems ☐cancer
☐mental illness ☐hypertension ☐diabetes ☐gout
☐other: _____

Social History (check all that apply)

Occupation:				
Work Status:	☐Employed	☐Retired	☐Unemployed	☐Disability leave
Marital Status:	☐Single ☐Co-habiting	☐Married	☐Divorced	☐Widowed
Who do you live with:	☐Alone ☐Other	☐Spouse/Sig. Other	☐Children	☐Roommate
Tobacco Use:	☐Never ☐Packs per day ____	☐Cigarettes For _____ years (total)	☐Cigar	☐Pipe chew ☐Quit _____ years ago
Alcohol Use:	☐Never ☐Alcoholic	☐Rare ☐Recovering Alcoholic	☐Social	☐Frequent (more than 2x per week)
Drug Use:	☐Never Types of Drugs:	☐In past	☐Currently	☐In treatment

Please mark the areas on your body where you are having symptoms. Use the symbol "XXXX." Just to complete the picture, please draw your face.



ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

Jeremy S. Smith, M D

New Spine Patient Medical and Surgical History

Review of Systems

Check all items that apply and describe below if necessary. Otherwise check "none."					NONE
☐Constitutional:	☐Weight loss	☐Weight gain	☐Fever	☐Chills	☐
☐Eyes:	☐Reading glasses	☐Change of vision			☐
☐Ears:	☐Hearing loss	☐Ear pain	☐Vertigo (dizziness)		☐
☐Nose/Mouth/Throat:	☐Nosebleeds	☐Hoarseness	☐Bleeding gums	☐Tooth/gum trouble	☐
☐Lungs:	☐Cough	☐Shortness of breath	☐Wheezing	☐Snoring	☐
☐Stomach:	☐Nausea	☐Ulcers	☐Vomiting	☐Stomach pain	☐
☐Bowels:	☐Diarrhea	☐Constipation	☐Bloody stool	☐Black stools	☐
☐Urinary Tract:	☐Difficulty starting urination		☐Frequent or burning urination		☐
☐Heart:	☐Chest pain	☐Palpitations	☐Abnormal heart beat	☐Swollen ankles	☐
☐Musculoskeletal:	☐Joint pain ☐Muscle pain	☐Swelling	☐Instability	☐Stiffness	☐
☐Skin:	☐Rashes ☐Poor healing	☐Itching	☐Skin changes	☐Redness	☐
☐Neuropathy:	☐Loss of feeling in:	☐Hands	☐Feet	☐Numbness	☐
☐Neurologic:	☐Seizures ☐Dizziness	☐Headaches	☐Memory loss	☐Uneasy gait	☐
☐Psychologic:	☐Sleep disturbance	☐Hallucinations	☐Frequent anxiety	☐Depression	☐
☐Blood:	☐Bleeding/bruising	☐Swollen lymph nodes	☐Blood clots	☐Anemia	☐
☐Non-Drug Allergies:	☐Foods	☐Seasonal	☐Other:		☐
☐Description/Other:					