Midwest Orthopaedic Center, SC

Spine Patient Questionnaire
Dr. Patrick O'Leary, M.D.

MIDWEST ORTHOPÆDIC CENTER

Today's Date: _____
Date of Birth: _____
Age: _____

Name: _____ Phone: _____
Mailing Address: _____
Occupation: _____ PCP: _____

1). Do you have back / neck pain? ❑ Back ❑ Neck

If yes, how long have you had it? _____

How did you injure your back / neck? ❑ No Injury ❑ Work Injury ❑ Car Accident ❑ Other

_____

_____

Pain Started On: _____ / _____ / _____ (Date of injury, accident, or onset of pain)

Previous spinal injury? ❑ Yes ❑ No **Prior Car Accident(s)?** ❑ Yes ❑ No

If yes, please explain: _____

_____

Have you been given a diagnosis for your pain? If so, what is it? _____

2). Do you have leg / arm pain? ❑ No (continue to questions #3)

If yes, which arm and / or leg hurts? ❑ Right leg ❑ Right arm ❑ Left leg ❑ Left arm

How long have you had the pain? _____

Pain Percentage: Back (_____%) vs. Leg (_____%) **AND / OR** Neck (_____%) vs. Arm (_____%)

Do you have any bowel or bladder problems? ❑ Yes ❑ No

3). Please list your prior surgeries: _____ (Date: _____ / _____ / _____)

❑ No prior surgeries _____ (Date: _____ / _____ / _____)

_____ (Date: _____ / _____ / _____)

_____ (Date: _____ / _____ / _____)

_____ (Date: _____ / _____ / _____)

4). Please list your medications and dosages: _____

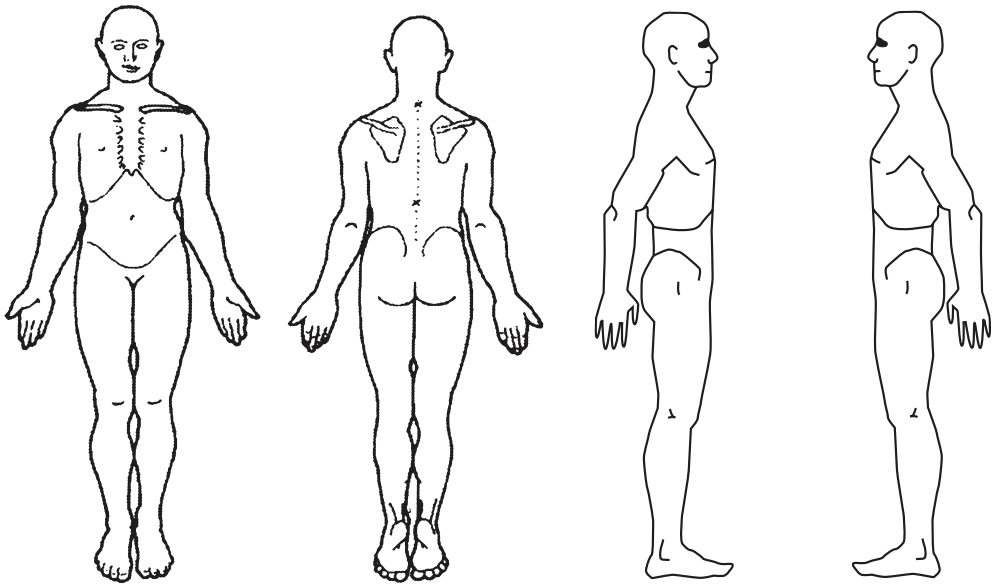
_____

_____

_____

5). Have you had a flu shot? ❑ No ❑ Yes, when? _____

Have you had a Pneumonia shot? ❑ No ❑ Yes, when? _____



Pain xxxx
Numbness oooo

6). Please mark in the pain diagram:

7). Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

No Pain **Maximum pain**

Average days: _____ (0-10) Good days: _____ (0-10) Bad days: _____ (0-10)

8). Height _____ Weight _____

9). Allergies? _____

10). Do you smoke? ❑ No If yes, how much? _____
Drink alcohol? ❑ No If yes, how much? _____

11). Have you received any of the following treatments for your spinal problems?
Physical Therapy ❑ No If yes, when and how long? _____
Spinal Injections ❑ No If yes, when and how many? _____
Surgery ❑ No If yes, please explain (include dates): _____
_____

12). What do you hope to accomplish with today's visit? _____
_____
_____
_____
_____
_____

Patrick O'Leary, M.D.
MOC 2012

REVIEW

Have you been diagnosed or received treatment for:

Ailment			Treatment, if answered yes
1) High blood pressure	❒ No	❒ Yes	_____
2) Heart disease	❒ No	❒ Yes	_____
3) Lung disease	❒ No	❒ Yes	_____
4) Diabetes	❒ No	❒ Yes	_____
5) Ulcers	❒ No	❒ Yes	_____
6) Liver/hepatitis	❒ No	❒ Yes	_____
7) Kidney disease	❒ No	❒ Yes	_____
8) Urinary/bladder disease	❒ No	❒ Yes	_____
9) Skin disease	❒ No	❒ Yes	_____
10) Blood/bleeding disorder	❒ No	❒ Yes	_____
11) Disease of the Nervous System	❒ No	❒ Yes	_____
12) Numbness in arms or legs	❒ No	❒ Yes	_____
13) Back/neck problems	❒ No	❒ Yes	_____
14) Psychiatric disorder	❒ No	❒ Yes	_____
15) Rheumatoid or osteoarthritis	❒ No	❒ Yes	_____
16) Cancer	❒ No	❒ Yes	_____
17) Seizure	❒ No	❒ Yes	_____
18) Blood clots	❒ No	❒ Yes	_____
19) Stroke	❒ No	❒ Yes	_____
20) Other ortho/medical problems not listed	❒ No	❒ Yes	_____

Illness	Mother	Father	Brother(s)	Sister(s)	Family
Alcohol	❑	❑	❑	❑	❑
Arthritis	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑
Depression	❑	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑	❑
Hypertension	❑	❑	❑	❑	❑
Scoliosis	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑