BOSTON ORTHOPAEDIC & SPINE

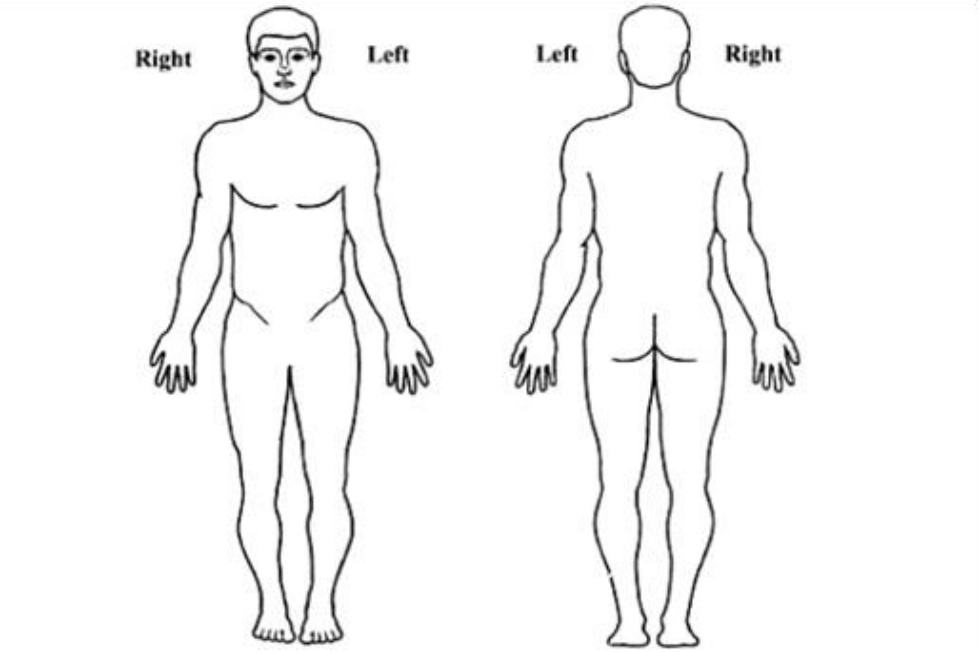
SPINE SURGERY CONSULTATION: NEW PATIENT INTAKE FORM

Please return this completed form 1 week prior to your scheduled appointment by EMAIL: dpatten@mybostonortho.com; MAIL: Boston Orthopaedic & Spine, LLC, 830 Boylston St Suite 211, Chestnut Hill, MA 02467; or FAX: 617-734-7804.

Patient Name: _____ **Date of Birth:** _____

Age: _____ **Height:** _____ **Weight:** _____

On the drawings below, please identify where you currently experience your main symptoms:



Since your symptom(s) began, have they: ◯ Improved ◯ Not changed ◯ Worsened

How long have you had your symptom(s): _____

Rate your pain from 0 to 10, where 0 means no pain and 10 means the worst pain imaginable:

Right now: ____ /10 At its worst: ____ /10 At its best: ____ /10

How do you describe your symptom(s): ◯ Sharp ◯ Burning ◯ Numbness ◯ Tingling ◯ Aching ◯ Throbbing ◯ Dull ◯ Soreness

Is there a lawsuit related to this health matter: ◯ No ◯ Yes

How did your symptom(s) begin:

◯ Spontaneous or gradual (no specific injury).

◯ Motor vehicle accident:

Were you wearing a seat belt: ◯ Yes ◯ No

Where were you in the car: ◯ Driver ◯ Front passenger ◯ Rear passenger

Where was the car hit: _____

Patient Name: _____ ***Date of Birth:*** _____

Date of motor vehicle accident: _____

Were airbags deployed: ◯ Yes ◯ No

Did you have symptoms prior to the accident: ◯ Yes ◯ No

Did you exit the vehicle on your own: ◯ Yes ◯ No

Did you go to the hospital after the accident: ◯ Yes ◯ No

◯ Fall:

What did you fall from: _____

Approximately how far did you fall: _____feet.

What did you land on: _____

◯ Job related (please describe): _____

Date of accident: _____

Is your injury being filed through worker's compensation: ◯ Yes ◯ No

◯ Sports / recreation (please describe): _____

What makes your symptom(s) BETTER:

◯ Walking ◯ Standing ◯ Lying down ◯ Sitting

◯ Bending forward ◯ Bending back ◯ Twisting ◯ Lifting

◯ Going up stairs ◯ Going down stairs ◯ Nothing in particular ◯ Leaning forward on a shopping cart

What makes your symptom(s) WORSE:

◯ Walking ◯ Standing ◯ Lying down ◯ Sitting

◯ Bending forward ◯ Bending back ◯ Twisting ◯ Lifting

◯ Going up stairs ◯ Going down stairs ◯ Nothing in particular

What treatment have you had for your symptoms:

◯ Modifying activities ◯ Tylenol ◯ NSAIDs (e.g. ibuprofen/Advil, naproxen/Aleve)

◯ Prescription pain medication – please list: _____

◯ Chiropractor ◯ Acupuncture ◯ Massage ◯ Heat/cold ◯ TENS unit

◯ Physical therapy – how many weeks of PT did you perform within last 6 months: _____

◯ Spinal injections: Facet injections: _____
Levels Date

RF ablation/rhizotomy: _____
Levels Date

Epidural injections: _____
Levels Date

Nerve root blocks: _____
Levels Date

Patient Name: _____ ***Date of Birth:*** _____

What diagnostics have you had:

◯ X-rays: _____
Region Date Facility

◯ CT: _____
Region Date Facility

◯ MRI: _____
Region Date Facility

◯ Myelogram: _____
Region Date Facility

◯ EMG: _____
Region Date Facility

Previous <u>spine</u> surgeries (type, date, hospital): _____

_____

Do you have any of the following:

◯ Urinary retention such that you cannot urinate despite feeling the need ◯ Persistent fevers or chills

◯ Loss of control of your bladder resulting in accidents ◯ Unexpected weight loss

◯ Loss of control of your bowel movements resulting in accidents ◯ Nausea/vomiting

◯ Constant numbness or tingling in your genital area ◯ Constant arm or leg weakness

◯ Worsening dexterity or coordination ◯ Difficulty with balance while walking

Are you right or left handed: ◯ Right ◯ Left

Do you live alone: ◯ Yes ◯ No – Who do you live with: _____

What is your current work/employment status:

◯ Employed – What kind of work do you do: _____

◯ Unemployed ◯ Retired ◯ Disabled

What is the highest level of education or degree you received: _____

Tobacco use: ◯ Current smoker, how much per day:

◯ 5 or less ◯ 6-10 ◯ 11-20 ◯ 21-30 ◯ 31+

◯ Former smoker, how long has it been:

◯ <1mo ◯ 1-3mo ◯ 3-6mo ◯ 6-12mo ◯ 1-5yr

◯ 5-10yr ◯ 10yr

◯ Never smoked.

Do you drink alcohol: ◯ No ◯ Yes (please state how much): _____ /week

Patient Name: _____ ***Date of Birth:*** _____

MEDICAL HISTORY:

Current prescription medications:

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

Current general medical issues:

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

Do you have any allergies to medications: ◯ No ◯ Yes (please list): _____

Are you allergic to latex: ◯ No ◯ Yes

Previous <u>non-spine</u> surgeries (type of surgery and date):

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

Have you ever had a blood clot: ◯ No ◯ Yes

Do any members of your family have:

◯ Coronary artery disease ◯ Hypertension ◯ Diabetes

◯ Cancer – What type: _____

◯ Other – Please list: _____

Please mark all of the following that apply to you:

<u>Constitutional</u>

◯ Fever ◯ Chills ◯ Loss of appetite ◯ Unexplained weight loss ◯ Fatigue

<u>Eyes</u>

◯ Blurred vision ◯ Double vision ◯ Abnormal vision

<u>Ears, Nose, Throat</u>

◯ Ringing in ears ◯ Room spinning ◯ Dizziness ◯ Sinus pain

◯ Mouth sores ◯ Sore throat

<u>Cardiovascular</u>

◯ Chest pain ◯ Ankle swelling ◯ Heart murmur ◯ Abnormal heart rhythm

Patient Name: _____ ***Date of Birth:*** _____

Respiratory

◯ Cough ◯ Wheeze ◯ Difficulty breathing

Neurologic

◯ Epilepsy ◯ Stroke ◯ Memory problems ◯ Headaches

Gastrointestinal

◯ Nausea ◯ Vomiting ◯ Stomach pain ◯ Ulcers

◯ Constipation ◯ Diarrhea ◯ Blood in stool ◯ Black tarry stools

Genitourinary

◯ Painful urination ◯ Blood in urine ◯ Loss of sexual desire

Musculoskeletal

◯ Painful joints ◯ Swollen joints ◯ Redness of joints

Integumentary/skin

◯ Sores ◯ Rash

Psychiatric

◯ Depression ◯ Anxiety

Hematologic/Lymphatic

◯ Unusual bleeding ◯ Easy bruising ◯ Swollen glands

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

THANK YOU