MMC
SPINE, JOINT AND PAIN CENTER

New Patient Medical Questionnaire

Patient Name _____ MRN _____ Date _____ Provider _____

Age _____ ☐ F ☐ M Dominant Hand ☐ R ☐ L Did you bring x-rays? ☐ Y ☐ N

Who requested that you visit this office? (Name)_____ ☐ MD ☐ PA ☐ Attorney ☐ None (Self-Referral)

Who is your Primary Care Doctor? _____ Preferred Pharmacy _____

What is the main reason for this visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Swelling ☐ Stiffness ☐ Other _____

How long ago did it start? ____Days ____Weeks ____Months ____Years Have you had a problem like this before? ☐ Y ☐ N

In this section, check the ONE BOX which best describes how your problem started.
Then answer the questions below the box you checked. Use as much space to the right as needed.

	ANSWER / COMMENTS
☐ **NO INJURY** (Onset was: ☐ Gradual or ☐ Sudden) Why do you think it started?	
☐ **INJURY** (☐ Accident ☐ Sport NOT Auto or Work) What sport _____ School _____	
☐ **INJURY AT WORK** Date _____ From a ☐ Lift ☐ Twist ☐ Fall ☐ Bend ☐ Pull ☐ Reach?	
☐ **WORK RELATED** (BUT NO INJURY) Date _____ How did your job cause this problem?	
☐ **AUTO ACCIDENT** Date_____ How was your car hit?	

On a scale of 0-10 (10 is the worst) how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10 _____

What is the quality of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

The pain is ☐ Constant ☐ Comes and goes (intermittent). Does your pain wake you from sleep? ☐ Yes ☐ No

Do you have? ☐ Swelling ☐ Bruise ☐ Numbness ☐ Tingling ☐ Weakness ☐ Loss of control of bowel or bladder

Since my problem started, it is: ☐ Getting Better ☐ Getting Worse ☐ Unchanged

What makes your symptoms worse? ☐ Standing ☐ Walking ☐ Lifting ☐ Exercise ☐ Twisting ☐ Lying in bed
☐ Bending ☐ Squatting ☐ Kneeling ☐ Stairs ☐ Sitting ☐ Coughing ☐ Sneezing

Which make your symptoms better? ☐ Rest ☐ Elevation ☐ Ice ☐ Heat ☐ Other _____

What medications are you taking now (or previously) for this problem? _____

Have you had any of these treatments? Injection ☐ Y ☐ N Brace ☐ Y ☐ N Physical Therapy ☐ Y ☐ N Cane/Crutch ☐ Y ☐ N

Were you seen in the E.R. for this problem? ☐ Y ☐ N Which E.R._____ Date _____

Are you here today as a result of the E.R. visit? ☐ Y ☐ N Who saw you in the E.R. (name)_____ ☐ MD ☐ PA

What tests/scans have you had for this problem ☐ X-rays ☐ MRI ☐ Cat Scan ☐ Bone Scan ☐ Nerve Test (EMG/NCV)

Have you already had surgery for a problem in the same area either recently or in the past? ☐ Y ☐ N Please list below

Procedure #1_____ Surgeon_____ City_____ Date_____

Procedure #2_____ Surgeon_____ City_____ Date_____

Current work status? ☐ Regular ☐ Light Duty (how long? _____) ☐ Not working due to this problem ☐ Disabled ☐ Retired ☐ Student

When is the last date you worked your regular job? _____

Are you currently receiving or plan to apply for: Disability ☐ Y ☐ N Workman's Comp ☐ Y ☐ N Unemployment ☐ Y ☐ N

Patient Name _____ MRN _____ Date _____ Provider _____

REVIEW OF SYSTEMS:

Circle any condition below that you have or Check None Describe

M/S	Gout	Back Pain	Osteoporosis	Rheumatoid Arthritis Fracture – Which bone?	☐	
GI	Heartburn	Ulcers	Nausea	Vomiting Blood in Stool	☐	
ENDO	Frequent Thirst	Frequent Urination	Always Hot or Cold		☐	
CONST	Weight Loss	Frequent Fever	Loss of Appetite		☐	
EYE	Blurred Vision	Double Vision	Vision Loss		☐	
ENT	Hearing Loss	Hoarseness	Trouble swallowing		☐	
C-VASC	Chest Pain	Palpitations			☐	
RESP	Chronic Cough	Shortness of Breath			☐	
GU	Painful Urination	Blood in Urine	Kidney Problems		☐	
SKIN	Frequent Rashes	Skin Ulcers	Psoriasis		☐	
NEURO	Headaches	Dizziness	Seizures		☐	
PSYCH	Drug/Alcohol Problem	Depression	Sleep Disorder		☐	
Allergies	Hay Fever				☐	
HEME	Easy Bleeding	HIV / AIDS	Hemophilia		☐	

Do you have ALLERGIES to medications? ☐ Y ☐ N If YES, list allergies:

PAST MEDICAL HISTORY

What MEDICATIONS do you take? ☐ None Please list below with dosage

Are you a DIABETIC? ☐ Y ☐ N Treatment: ☐ Insulin ☐ Oral ☐ Meds ☐ Diet ☐ None

HAVE YOU EVER HAD?: Circle any conditions below: ☐ I do not have any of the conditions listed below

Asthma	Sulfa allergy	Heart attack (year)	Stroke
Aspirin Sensitivity	Kidney Failure	High Blood Pressure	Cancer (location)
Stomach Ulcers	Hepatitis	Heart Failure	Notes:
Bleeding Ulcers	Liver Disease	COPD	

Stomachache taking anti-inflammatories (NSAIDS) Which NSAIDS?

Blood Clots that you had to take blood thinners to treat? ☐ Y ☐ N When?

PAST SURGICAL HISTORY

What operations have you had? When? ☐ None _____

_____

Have you ever had a reaction to anesthesia? ☐ Y ☐ N

Past Hospitalizations (Not for Surgery) ☐ None _____

FAMILY HISTORY Have any direct relatives had any of the following disorders? If so, which relative?

☐ Hemophilia _____ ☐ High Blood Pressure_____ ☐ Diabetes_____ ☐ Rheumatoid Arthritis_____ ☐ None

Do any direct relatives have the same condition you are being seen for today? ☐ Y ☐ N Relationship_____

SOCIAL HISTORY

Do you use tobacco? ☐ Y ☐ N packs per day_____ Alcohol use? ☐ None ☐ Social ☐ Daily ☐ Frequently

Marital Status: M S D W How many people live with you? _____

Occupation: _____ ☐ Student Employer:_____

Do you like your job? ☐ Y ☐ N Do you plan to be working 6 months from now? ☐ Y ☐ N

LIVING ENVIRONMENT

☐ House Number of stairs to enter home _____ Number of floors _____

What floor is the bedroom ☐ 1st floor ☐ 2nd floor ☐ 3rd floor

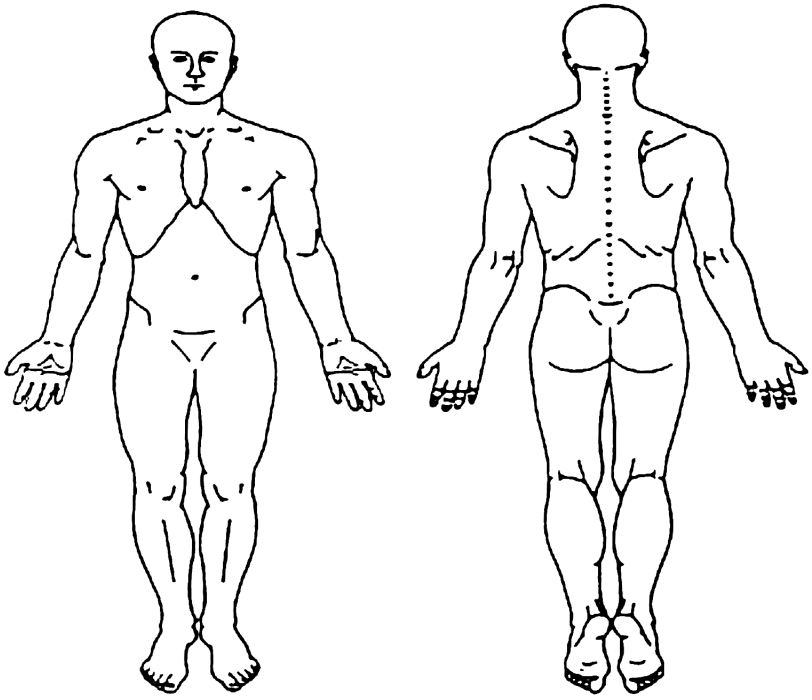
Apartment/Condo/Town Home Which floor _____ Elevator ☐ Y ☐ N Number of stairs to enter home _____

What floor is the bedroom ☐ 1st floor ☐ 2nd floor ☐ 3rd floor

ORTHO PAIN CHART

Mark the areas on your body where you feel the described sensations using the appropriate symbol form the list below. Please include all affected areas.

Numbness	= = =
Pins & Needles	o o o
Burning/Aching	x x x
Stabbing	/ / /



PLEASE SIGN: The information on these three forms is accurate to the best of my knowledge. _____

For Office Use Only	BP _____/_____ Pulse _____ Temp_____ Wt _____
Complete _____ Date_____ Review by _____ D.O.	Hgt_____/_____ O2 Sat_____