orthopedics of oregon

New Patient Form-Neurosurgery

Patient's name: ______________________ **DOB:** ____________

- Reason for your visit: ______________________
- Are you: ☐ Left handed ☐ Right Handed

HISTORY OF PRESENT ILLNESS:

- ***What symptoms are you experiencing?***

  ☐ Pain ☐ Numbness ☐ Tingling ☐ Muscle spasm

  ☐ Headache ☐ Weakness ☐ Balance problems ☐ Incontinence

  ☐ Other: ______________________

- **How long have you had the problem?** ______________________
- **How often do the symptoms occur?**

  ☐ Constant ☐ Occasionally ☐ Every day ☐ Other: ____________

- **How severe is your pain?** (Please, circle lowest and highest, 0= no pain, 10= unbearable pain)

  0 1 2 3 4 5 6 7 8 9 10

- **How long do the symptoms last?** ______________________

- **Have you had recent changes in bowel or bladder function:**

  ☐ No ☐ Yes: ______________________ ☐ Difficulty with emptying bladder

  ☐ Constipation ☐ Diarrhea ☐ Bowel incontinence ☐ Bladder incontinence

- **What makes the symptoms <u>BETTER</u>?**

  ☐ Sitting ☐ Standing ☐ Laying down ☐ Walking ☐ Lifting

  ☐ Bending forward ☐ Leaning back ☐ Other: ____________

- **What makes the symptoms <u>WORSE</u>?**

  ☐ Sitting ☐ Standing ☐ Laying down ☐ Walking ☐ Lifting

  ☐ Bending forward ☐ Leaning back ☐ Other: ____________

- **Does coughing, sneezing, or straining bother you?** ☐ Yes ☐ No
- **Are you able to put your shoes and socks on?** ☐ Yes ☐ No
- **Are you able to dress yourself?** ☐ Yes ☐ No
- **Are you able to work?** ☐ Yes ☐ No
- **Are you applying for disability?** ☐ Yes ☐ No

- **How far can you walk?** ______________________ ☐ No Limit
- **Have you tried physical therapy in the last 12 months?** ______________________

  If so where? ______________________

- **Have you had spinal injections in the past 12 months?** ______________________

  If so where? ______________________

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PRIOR TREATMENTS: Within the last **12 months** please mark treatment:

Treatment you have tried for this problem :	Made Worse	No Change	Some Relief	Significant Relief
Bed Rest:				
Physical Therapy:				
Traction:				
TENS unit				
Pain Management/Injections:				
Chiropractor:				
Neck Collar/ Back Brace:				
Application of Heat:				
Previous Spine Surgery:				

Mark any medication used to treat this problem:	Made Worse	No Change	Some relief	Significant Relief
NSAIDS: (Motrin/Aleve/Ibuprofen)				
Steroids: (Prednisone/Medrol Dose Pack)				
Oral Opioids (Vicodin/Percocet):				
Neurontin/Gabapentin/Lyrica:				
Tramadol/Ultram:				
Muscle relaxants:				
Tylenol:				

- Have you had a Dexa scan done in the last two years?_______________Where?________________________
- Have you had your Vitamin D Level checked in the last two years?____________Where?_____________________

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REVIEW OF SYSTEMS:

Please, mark medical conditions below which apply to you either <u>now or in the past year</u>:

CONDITION	YES	NO
Fatigue		
Fevers		
Weight gain		
Weight loss		
Hearing loss		
Visual changes		
Chronic cough		
Shortness of breath		
Wheezing/asthma		
Chest pain		
Edema/Leg swelling		
Palpitations		
Abdominal pain		
Constipation		
Diarrhea		
Loss of appetite		
Nausea		
Vomiting		
Urinary incontinence		
Urinary retention		
Recurrent UTI		
Cold intolerance		
Heat intolerance		

CONDITION	YES	NO
Dizziness		
Arm numbness		
Leg numbness		
Arm weakness		
Leg weakness		
Seizures Tremors		
Gait disturbance		
Head ache		
Memory loss		
Anxiety		
Depression		
Insomnia		
Rash		
Skin lesion		
Back pain		
Joint pain		
Joint swelling		
Muscle weakness		
Neck pain		
Easy bleeding		
Easy bruising		
Latex allergy		

PLEASE SHADE PARTS OF THE BODY AFFECTED: