RIES SPINE HISTORY

Date: _____

Name: _____ Date of Birth: _____

1. Why are you seeing the doctor today? _____
2. How long has pain/condition been present? _____
3. Has pain/condition worsened recently? ☐ No ☐ Yes, how recently? _____
4. What started the pain/condition? _____
5. How do you rate your pain?

Back/Neck Pain

0 1 2 3 4 5 6 7 8 9 10

No Pain Slight Mild Moderate Severe Excruciating Worst Imaginable

Arm/Leg Pain

0 1 2 3 4 5 6 7 8 9 10

No Pain Slight Mild Moderate Severe Excruciating Worst Imaginable

6. Quality of the Pain: ☐ Sharp ☐ Burning ☐ Dull ☐ Aching ☐ Other: _____
7. How much of your pain is in your Neck/Back or Arm/Leg (Please give a percentage – i.e. 50)

Neck: _____ Arm and which side: _____

Back: _____ Leg and which side: _____

8. Location of the Pain/Condition:

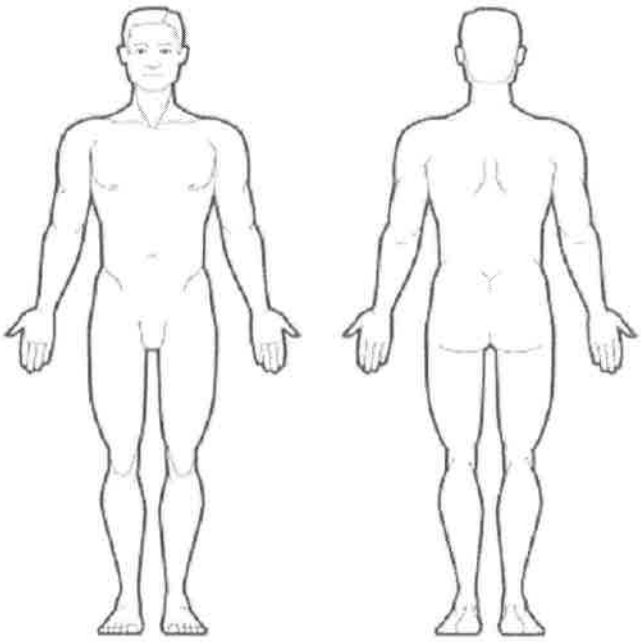
Stabbing Pain //////

Burning Pain OOOO

Aching Pain XXXXX

Pins/Needles VVVVV

Numbness +++++



FOR OFFICE USE ONLY

HT: _____ WT: _____

BMI: _____ Temp: _____

9. What makes the pain/condition better?_____

10. What makes the pain/condition worse?_____

11. Is the pain/condition:

☐ Continuous ☐ Activity Related ☐ Night Pain ☐ Other:_____

12. Did the pain start at work? _____

- Have you filed a worker's compensation claim? _____

13. Have you ever lost bowel or bladder control? _____

14. Have you had spine surgery before? If so, what surgery?_____

- Did it help?_____

15. Treatments have included: ☐ No medications, therapy, manipulations/chiropractor, injections, or braces

CIRCLE TREATMENT IF IT HELPED:

☐ Physical Therapy, exercise
☐ Massage or ultrasound
☐ Traction
☐ Chiropractor
☐ Tens Unit
☐ Brace
☐ Anti-inflammatory Medications
☐ Narcotic Medications
☐ Epidural injections (how many?___)
☐ Trigger point injections
☐ Other:_____

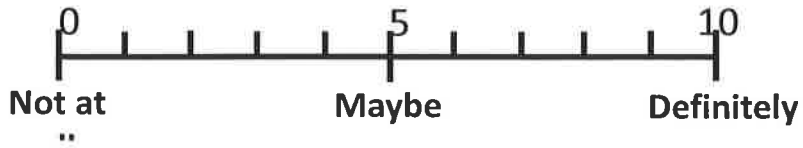
16. If you have seen other surgeons for this problem and were not happy, why?

☐ Did not answer my questions
☐ Had no suggestions on what to do
☐ Personality issues
☐ Office staff issues
☐ Spent too little time with me
☐ Other_____

17. My main goal(s) today is (are) to get (check all that apply):

☐ Second opinion
☐ Recommendation for Physical Therapy
☐ Medications
☐ Injection Treatments
☐ Surgery
☐ Other_____

If recommended, please rate how interested you are in having **surgery** to treat your problem:



RIES HEALTH HISTORY

Primary Care Provider: _____ Referring Doctor: _____

Pharmacy name and location: _____

List medication you have taken for THIS problem:

Medication:	Dose:	Frequency:	Taken for:

List ALL CURRENT medications:

Medication:	Dose:	Frequency:	Taken for:

Over the counter/ herbal medications: _____

List all allergies: _____

RIES HEALTH HISTORY

PAST MEDICAL HISTORY: **Check all that apply** ☐ **None Apply**

☐ High blood pressure	☐ Stomach ulcers	☐ Rheumatoid arthritis	☐ Neurofibromatosis
☐ Heart Attack	☐ Tuberculosis	☐ Osteoarthritis	☐ Seizures
☐ Abnormal heartbeat	☐ COPD	☐ Gout	☐ Migraine
☐ Heart failure	☐ Thyroid	☐ Osteoporosis	☐ Spina bifida
☐ Stroke	☐ Asthma	☐ Cirrhosis	☐ Depression
☐ Blood clots (leg)	☐ Gastric reflux	☐ Hepatitis (A, B or C)	☐ MRSA
☐ Blood clots (lung)	☐ Hernia	☐ HIV/AIDS	☐ Cerebral palsy
☐ Poor circulation	☐ Kidney failure	☐ Bleeding disorder	☐ Anemia
☐ High cholesterol	☐ Kidney stones	☐ Neuropathy	☐ Fibromyalgia

☐ Cancer: If yes, specify type/treatment:_____

☐ Diabetes: Hemoglobin A1c number:_____ ☐ Insulin

☐ Other:_____

PAST SURGICAL HISTORY: ☐ **No Prior Surgery**

Operation	Year	Surgeon/Hospital

SOCIAL HISTORY:

Work Status: ☐ Working ☐ Homemaker ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Children: ☐ No ☐ Yes, How Many?_____

Do you live alone? _____ If no, who lives with you?_____

Are you currently smoking?_____ If yes, how many packs/day?_____ For how many years? ____

Alcohol use: ☐ No ☐ Yes How many drinks per week?_____

Drug use: ☐ No ☐ In the past ☐ Currently If current or past use, what type of drugs?_____

FAMILY HISTORY:

Do any health problems, cancers or diseases run in your family? ☐ No ☐ Yes

If yes, please explain:_____

Do any anesthetic complications run in your family?_____

Mother: ☐ Alive ☐ Deceased Age/Age at death: _____

Health status or cause of death: _____

Father: ☐ Alive ☐ Deceased Age/Age at death: _____

Health status or cause of death: _____

Sibling(s): Health status or cause of death:

Brother(s):_____

Sister(s): _____

REVIEW OF SYSTEMS: **Have you experienced any of the following in the past 30 days?**

Circle all that apply:

CONSTITUTIONAL: weight loss weight gain fevers chills sweats

EYES: problems with vision cataracts glasses/contacts

EARS, NOSE, THROAT: difficulty with hearing ringing in ears swallowing problems

CARDIOVASCULAR: chest pains palpitations congestive heart failure swelling

RESPIRATORY: shortness of breath pneumonia bronchitis cough

GASTROINTESTINAL: gastric reflux diarrhea constipation abdominal pain

GENITOURINARY: difficulty with urination incontinence (difficulty controlling urination)

MUSCULOSKELETAL: arthritis gout

INTEGUMENT: skin rashes swollen glands skin sores/ulcers easy bruising

NEUROLOGIC/PSYCHIATRIC: memory problems blackouts headaches hallucinations