New Patient Questionnaire

Wisconsin Brain & Spine Center
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Name: _____ DOB: _____ Gender: _____ Date: _____

Address:_____ Phone- Home/Cell: _____
_____ Phone- Work/Other: _____

How did you hear about our clinic and physicians? Dr. Referral____ Family Friend____ Newspaper___ Internet___
Radio___ Other____ Please explain_____
Name and address of referring physician(s) you would like to receive copies of your evaluation:

1. _____
2. _____
3. _____

Which is your dominant hand? Right Left Ambidextrous

CHIEF COMPLAINT: _____

_____

HISTORY OF CURRENT ILLNESS/INJURY: _____

_____

MEDICAL HISTORY: Do you/have you had any of the following? (please circle all that apply)

Allergies to food/medicine	Mitral Valve Prolapse	Hay Fever	Depression
Cancer _____ (type)	Hepatitis (A, B or C)	Heart Attack	Emphysema
Congestive heart failure	Thyroid Problems	Epilepsy	Glaucoma
Chronic Obstructive Pulmonary Disease	Kidney Problems	Liver Problems	Gout
Gastroesophageal Reflux Disease	High Blood Pressure	Arthritis	Heart Murmur
Headaches (Migraine / Tension)	Diabetes Mellitus	Stroke	Seizures
Hearing Loss (R – L – Both)	Coronary Heart Disease	TIA's	Ulcers
Recent upper respiratory infection	Difficulty swallowing	Asthma	Rheumatic fever
Environmental Allergies	Poor leg circulation	Cataracts	TB Tremors

SURGERIES: Please list type of surgery, year done and the name of the surgeon.

Type of surgery	Date of surgery	Surgeon

PREVIOUS ILLNESSES/INJURIES: _____

_____

_____

HOSPITALIZATIONS: _____

_____

_____

Pharmacy Name **Number** **City** **State**

DRUGS / VITAMINS / HERBS: Please list all medications you are presently taking, dosages and frequencies.

Name **Dosage** (i.e.: 10 mg) **Frequency** (i.e.: 1 every day)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Please list DRUG Allergies and Symptoms: _____
_____

Please list FOOD Allergies and Symptoms: _____
_____

SOCIAL HISTORY:

Marital Status: Single Married Separated Divorced Widowed

Do you smoke cigarettes? YES NO Packs per day _____ # of years _____

Do you smoke cigars? YES NO Cigars per day _____ # of years _____

Do you use chewing tobacco? YES NO Times per day _____ # of years _____

Do you use illicit or non-prescribed drugs? YES NO

Alcohol intake: Beer Wine Alcohol Amount per week _____

Occupation: _____ Children ____ Male ____ Female ___

City of Residence: _____ City of Birth: _____

Current stresses in your life: _____
_____

Years of education: 8-11 years 12 years 12-16 years More than 16 years

FAMILY HISTORY:

Is your father still living? YES NO If no, age deceased: ____ Cause of death: _____

Is your mother still living? YES NO If no, age deceased: ____ Cause of death: _____

Please check any of the following diseases that apply to your family members:

DISEASE	Mother	Father	Sister/Brother
Anemia	_____	_____	S_____ B_____
Aneurysm (Brain)	_____	_____	S_____ B_____
Bleeding Problems	_____	_____	S_____ B_____
Brain Tumor	_____	_____	S_____ B_____
Cancer	_____	_____	S_____ B_____
Type of cancer	_____	_____	_____
Diabetes	_____	_____	S_____ B_____
Disk Surgery	_____	_____	S_____ B_____
Headaches	_____	_____	S_____ B_____
Heart Disease	_____	_____	S_____ B_____
High Blood Pressure	_____	_____	S_____ B_____
Kidney Disease	_____	_____	S_____ B_____
Lung Disease	_____	_____	S_____ B_____
Problems with Anesthesia	_____	_____	S_____ B_____
Strokes	_____	_____	S_____ B_____

REVIEW OF SYSTEMS: (Circle current symptoms or abnormalities)

Constitutional Loss of appetite, Chills, Chronically ill, Decreased energy, Fatigue, Fever, General discomfort, Lethargy, Night sweats, Tires easily, Weight gain, Weight loss

Eyes Blind spots, Blurred vision, Bumps into things frequently, Cataracts, Discharge from eye, Disease, Double vision, Drooping eyelids, Dry, Flashing light difficulty, Glasses/contacts, Glaucoma, Halos around lights, Itchy, Loss of vision, Night vision difficulties, Eye pain, Eye discomfort, Impaired vision

HENT Bleeding gums, Headaches, Difficulty swallowing, Discharge, Dryness, Hoarseness, Hearing loss, Itching, Lip abnormalities, Mouth sores, Nasal lumps, Nose bleeds, Pain, Recent infections, Ringing, Sensitive to loud noises, Sinus congestion, Tongue burning, Tongue soreness

Breast/Chest Nipple discharge, Enlargement, Inflammation, Lumps, Operations, Pain, Skin changes

Cardiovascular Arrhythmia, Ankle swelling, Chest pain, Congestive heart failure, Coronary artery disease, Difficulty breathing when lying down, Hypertension, Inability to breath except in an upright position, Mitral valve prolapse, Palpitations, Shortness of breath with inactivity, Rapid irregular heartbeat, Rheumatic fever

Respiratory Asthma, Bronchitis, Chronic Obstructive Pulmonary Disease, Coughing up blood, Emphysema, Lung tremors, Persistent cough, Pleurisy, Pneumonia, Recent upper respiratory infection, Shortness of breath, Tuberculosis, Wheezing

Gastrointestinal Abdominal pain, Bloating, Blood in stool, Diarrhea, Diverticulitis, Colitis, Constipation, Food intolerance, Gastro Esophageal Reflux, Heartburn, Hernia, Hepatitis (A, B or C), Indigestion, Jaundice, Liver problems, Nausea, Pain, Rectal problems, Ulcers, Vomiting, Yellow skin

Genitourinary Blood in urine, Change in sexual function/desire, Change in scrotum, Discharge, Genital sores/pain, Infections, Incontinence, Increased frequency of urination, Kidney stones, Kidney problems, Leakage, Menstrual difficulties, Pain with urination, Prostate problems, Recent infections, Testicular pain, Testicular tumor, Urgency, Venereal disease

Integument Blisters, Blotchy, Change in a mole, Cracks, Dryness, Flaking, Growths, Hives, Itching, Lumps, Painful areas, Sensitive to sunlight, Skin discolor, Sores, Ulcers

Neurological Balance difficulties, Burning sensations, Change in thought patterns, Confused, Convulsions, Decreased touch sensation, Difficulty concentrating, Difficulty walking, Dizziness, Drags one foot, Epilepsy, Fainting, Falls frequently, Headaches (migraine/tension), Lack of coordination, Lightheadedness, Loss of consciousness, Memory problems, Numbness, Paralysis, Seizures, Speech difficulties, Staring spells, Strokes, TIA's, Tingling, Tremors, Unsteady gait, Weakness

Musculoskeletal Arthritis, Atrophy, Back ache, Coordination difficulties, Degenerative disc disease, Degenerative joint disease, Difficulty walking, Fibromyalgia, Joint inflammation, Joint redness, Joint swelling, Muscle atrophy, Muscle pain, Muscle swelling, Muscle weakness, Numbness, Osteopenia, Osteoarthritis, Reduction of motion in a joint, Stiffness

Endocrine Change in appetite, Diabetes Mellitus, Eye bulging out, Excessive thirst/hunger/urination, Has taken cortisone in the past, Heat/Cold intolerance, Hot flashes, Redness of skin, Sweats, Thyroid problem

Psychiatric Changes in personality, Compulsive behavior, Depression, Difficulty coping, Hostile, Increased nervousness, Insomnia, Irritable, Mood changes, Restlessness, Sleep disturbances, Stress, additional symptoms except as noted in the HPI

Heme-lymph Anemia, Bleeds easily, Easily bruised, Inflammation of vein, Poor leg circulation, Swollen nodes

Allergic-Immunologic Chronic immunity problems, Hay fever, History of environmental allergies

Can you receive blood products? YES NO

Females:

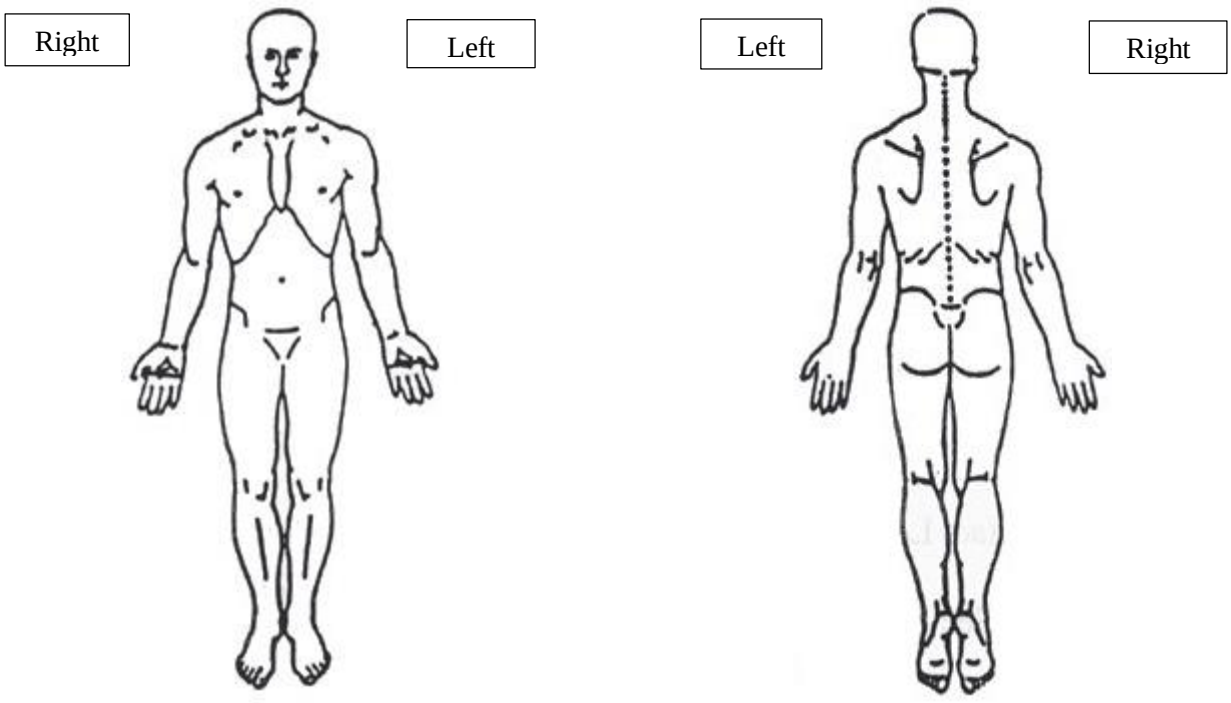
Last period _____
Number of miscarriages/abortions _____
Have you had your uterus removed? YES NO
Do you take hormones? YES NO
Do you have lactation from the breast? YES NO

Number of pregnancies _____
Have your periods stopped? YES NO
Have you had your ovaries removed? YES NO

PAIN DIAGRAM

Please complete the diagram below to demonstrate the location for your pain. Use the symbols in the legend to indicate intensity. **Please circle the area the pain is worst at this time.**

Aching	Numbness	Pins & Needles	Burning	Stabbing
***	====	000	xxx	///



On a scale of 1 to 10, how bad is your pain? (1 = no pain; 10 = worst pain imaginable)

At its very worst:	1	2	3	4	5	6	7	8	9	10
Right now:	1	2	3	4	5	6	7	8	9	10

Overall, is your pain generally: ____ Improving ____ Same ____ Worsening