



ARIZONA
SPINE CARE
Orthopedic New Patient Questionnaire

Name: _____
 Date of Injury: _____
 AZ Spine Care MR# _____

Today's Date: _____
 Height: ___ ft ___ in Weight: _____
 Date of Birth: _____

1. What is your chief complaint? _____

a. Where is your pain? _____

2. How and when did your injury begin? _____

3. Did you have any other injuries or related problems? _____

4. Medications: NONE: _____	Dosages: _____	Frequency: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Preferred Pharmacy? _____ Location: _____

6. Allergic to any medications: Please Check: Yes _____ No _____

Medication _____ Reaction _____

Medication _____ Reaction _____

Medication _____ Reaction _____

Past Medical History

7. Please mark any of the following medical problems you have had:

- | | |
|--------------------------------------|-----------------------------------|
| ___ 1. Ulcers | ___ 2. Prostate problems |
| ___ 3. Ulcerative colitis | ___ 4. Hepatitis type: _____ |
| ___ 5. Psoriasis | ___ 6. Diabetes type: _____ |
| ___ 7. Arthritis (not spine related) | ___ 8. Heart disease/heart attack |
| ___ 9. Tuberculosis | ___ 10. Stroke |
| ___ 11. Cancer | ___ 12. Asthma |
| ___ 13. HIV positive | ___ 14. Depression |
| ___ 15. Seizure | ___ 16. High Blood Pressure |

17. Kidney / Bladder infections 18. Other _____
 19. Kidney Stones 20. None _____

8. List all previous hospitalizations that were not for surgery: _____

9. Past surgical history: NONE: _____

Date of surgery	Type of surgery	Describe recovery
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History: (Does any member of your biological family have one or more of these conditions?)

10. Please mark conditions in your immediate family: NONE: _____

- Cancer Diabetes Heart Disease Stroke
 Arthritis Back Pain Bleeding tendencies Anesthesia difficulties
 Malignant hyperthermia

11. Social History:

- Tobacco use Yes ___ No ___ Amount _____
 Alcohol use Yes ___ No ___ Amount _____
 Substance abuse Yes ___ No ___ Amount _____
 Married _____ Single _____ Divorced _____ Widowed _____
 Children Yes ___ No ___ Ages _____
 Type of work/Occupation? _____ Last Day Worked? _____

12. Race: White _____ African American _____ Pacific Islander _____ Asian _____ Other: _____
 Ethnicity: Hispanic _____ Non-Hispanic _____

13. REVIEW OF SYSTEMS:

Please **MARK "X"** next to your current symptoms:

1. Skin:

- rashes
 psoriasis
 bruise easily
 abnormal lumps
 painful breasts

3. Respiratory:

- shortness of breath
 wheezing
 cough/ sputum production

5. Genitourinary:

- blood in urine
 increased frequency
 of urination
 painful urination
 loss of bladder control
 kidney stones

2. Eyes:

- visual
 double vision

4. Gastrointestinal:

- weight loss
 abdominal pain
 nausea/vomiting
 diarrhea or constipation
 blood in stool
 loss of bowel control

6. Ears
____ decreased hearing
____ ringing in ears

7. Musculoskeletal:
____ fractures/sprains
____ osteoporosis
____ joint swelling

8. Nose
____ breathing problems
____ sinus problems

9. Throat
____ sore throat
____ hoarseness
____ snoring

10. Endocrine:
____ enlarged thyroid/goiter
____ excessive thirst/appetite
____ diabetes

11. Cardiovascular:
____ palpitations/irregular heartbeat
____ heart murmur/ rheumatic fever
____ chest pain

12. Neurological:
____ headache/migraine
____ dizziness
____ convulsions/seizures
____ loss of consciousness

13. Was this a work related injury? _____

14. Who referred you to Arizona Spine Care?

- ____ 1. Primary doctor
- ____ 2. Physical therapist
- ____ 3. Patient
- ____ 4. Other

Name: _____
Address: _____
Phone: _____ Fax: _____

If a doctor requested you visit Arizona Spine Care, please sign below if you wish to authorize the release of this and all subsequent reports to the above named physician

I Authorize this release/Signature: _____

Check here if you do NOT authorize this release:

15. Emergency Contact or Next of Kin (Family Member) Name: _____
Phone Number: _____

16. Have you been treated by a physical therapist for this injury? ____ 1. Yes ____ 2. No