

**The Brain & Spine Institute at Gwinnett Medical Center**

**NEW PATIENT OR PROBLEM**

(PART 1)

**PATIENT MEDICAL QUESTIONNAIRE**

NAME: \_\_\_\_\_

DATE \_\_\_\_\_ AGE \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

**MAIN PROBLEM**

(Circle all that apply)

Back pain / Leg pain / Both back & leg pain / Neck pain / Arm pain / Both neck & arm pain

Pain despite injections

Pain despite surgery

Other: \_\_\_\_\_

**CHARACTERISTICS & HISTORY OF THE PAIN:**

A/ CONTEXT:

What started the pain (circle all that apply)? A bad movement / the onset was slow and progressive / a work injury / a car accident / other: \_\_\_\_\_

If due to an injury, when was the date of injury? \_\_\_\_\_

How did it happen?

\_\_\_\_\_  
\_\_\_\_\_

B/ WHERE IS THE PAIN? (Circle all that apply)

**Neck**

**Right arm:** Shoulder/ Arm/ Hand / Thumb & 1<sup>st</sup> finger / Small fingers.

**Left arm:** Shoulder/ Arm/ Hand / Thumb & 1<sup>st</sup> finger / Small fingers.

**Upper back:** Between the shoulders / Coming around the chest to the side or front.

**Lower back:** Center / Right / Left

**Right leg:** Hip & Thigh (inside/ outside). Lower leg (inside/ outside). Foot (inside/ outside).

**Left leg:** Hip & Thigh (inside/ outside). Lower leg (inside/ outside). Foot (inside/ outside).

**Other:** \_\_\_\_\_

C/ WHAT KIND OF PAIN IS IT? (Circle all that apply)

Sharp / stabbing / burning / deep aching / pins & needles / numbness / cramps / diffuse

Other: \_\_\_\_\_

D/ SEVERITY:

On a scale of 0 to 10 (0 being no pain and 10 being the worse pain possible) how bad is the pain:      **0   1   2   3   4   5   6   7   8   9   10**





## FAMILY HISTORY

Circle the medical conditions that apply to family members.

CANCER: Mother / father / brother / sister / grandparent / aunt & uncle

DIABETES: Mother / father / brother / sister / grandparent / aunt & uncle

HEART DISEASE: Mother / father / brother / sister / grandparent / aunt & uncle

HIGH BLOOD PRESSURE: Mother / father / brother / sister / grandparent / aunt & uncle

TUBERCULOSIS: Mother / father / brother / sister / grandparent / aunt & uncle

OTHER: \_\_\_\_\_

\_\_\_\_\_

## SOCIAL HISTORY

Occupation: \_\_\_\_\_

Marital status: [Single] [Married] [Divorced] [Widowed]

Do you smoke? No / Yes How many packs/day: \_\_\_\_ If you quit, give date: \_\_/\_\_/\_\_

Do you drink alcohol? No / Socially / More (drinks/day \_\_\_\_\_)

Do you use illegal drugs? No / Yes (which one? \_\_\_\_\_)

Do you exercise regularly? Yes / No

Relative(s) or others you live with? \_\_\_\_\_

## REVIEW OF SYSTEMS

(circle all that apply):

1/ CONSTITUTIONAL: Appetite change / weight change / fever / chills / malaise / fatigue

2/ SKIN: Itching / rash / hives / skin cancer

3/ ALLERGY/IMMUNE: Cancer / seasonal allergies / asthma

4/ ENT: Hearing changes / ringing / nose bleeds

5/ EYES & HEAD: Vision changes/ headaches / dizziness

6/ RESPIRATORY: Shortness of breath / cough / wheezing

7/ CARDIOVASC: Chest pain / edema / fainting / varicose veins

8/ GI: Indigestion & heartburn / belly pain / diarrhea / constipation / blood in stools / bowel changes

9/ GU: Pain when urinating / blood in urine / difficulties urinating / discharge

10/ ENDOCRINE: Breast mass or discharge / diabetes / steroid use

11/ MUSCULOSKELETAL: Bursitis / gout / stiffness / osteoporosis

12/ NEURO: Seizures / stroke / paralysis / speech problems

13/ PSYCHIATRIC: Anxiety / depression / stress

14/ HEME/LYMPH: Anemia / bruise easily / bleeding / swollen glands

OTHER: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**PHYSICIAN REVIEW & SIGNATURE**

(For physician only)

Reviewed with patient by physician? Yes / No

PHYSICIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

RE-REVIEWED WITH PATIENT (Date/ Patient signature/ Physician signature/ Change):

D:\_\_\_ Pat. \_\_\_\_\_ Phys. \_\_\_\_\_ Change: \_\_\_\_\_

D:\_\_\_ Pat. \_\_\_\_\_ Phys. \_\_\_\_\_ Change: \_\_\_\_\_

D:\_\_\_ Pat. \_\_\_\_\_ Phys. \_\_\_\_\_ Change: \_\_\_\_\_

D:\_\_\_ Pat. \_\_\_\_\_ Phys. \_\_\_\_\_ Change: \_\_\_\_\_

D:\_\_\_ Pat. \_\_\_\_\_ Phys. \_\_\_\_\_ Change: \_\_\_\_\_

**HISTORY GRID:**

**HPI:** Brief: 1-3 elements. Extended: 4 or more elements

**PFSH:** Pertinent: 1 of 3. Complete (new) 3 of 3. Complete (established) 2 of 3

**ROS:** Problem pertinent: 1system. Extended: 2-9 systems. Complete = 10 or more.

HPI	PFSH	ROS	RESULT
Brief	N/A	N/A	Problem focused
Brief	N/A	Problem pertinent	Expanded
Extended	Pertinent	Extended	Detailed
Extended	Complete	Complete	Comprehensive