FLORIDA ORTHOPAEDIC INSTITUTE SPINE
FIRST VISIT QUESTIONNAIRE

Please circle answers to questions that pertain to your problem. You may select more than one answer per question. This information will help get an accurate appraisal of your problems, develop an appropriate plan of treatment, and will be included in your visit note. If you have any questions, please ask for assistance.

Referred by: _____ Is this a second opinion? _____

NAME_____ MR#_____ DATE_____ DR_____
AGE: _____ ARE YOU: (A) Right handed (B) Left handed (C) Ambidextrous
SEX: (A) Male (B) Female OCCUPATION: _____

COMPLAINT (What are you being seen for?)

A. Neck pain
B. Neck Pain with headaches
C. Upper Back Pain
D. Lower Back Pain
E. Right Leg Pain
F. Left Leg Pain
G. Right Arm Pain
H. Left Arm Pain
I. Scoliosis
J. Other _____

Do you have any:

A. Weakness
B. Numbness
C. Tingling
D. If so, where?
Describe_____

If one or more of the above is chosen, which is the most problematic? _____

Which term best describes your neck/back pain?

A. Sharp
B. Stabbing
C. Burning
D. Like electricity
E. Dull ache
F. Pins and needles

Which term best describes your arm/leg pain?

A. Sharp
B. Stabbing
C. Burning
D. Like electricity
E. Dull ache
F. Pins and needles

When did the problem start? _____

If problem was caused from an injury, what is the date of injury? _____
Was the injury job related? (A) Yes (B) No

How did the injury occur? (20)

A. No injury
B. Motor vehicle accident - no litigation
C. Motor vehicle accident - litigation pending
D. Motor vehicle accident - litigation complete
E. Fall
F. Sports or recreation
G. Job related
H. Other _____

If motor vehicle accident, were you:

A. Driver
B. Front seat passenger
C. Rear seat passenger
D. Motorcycle driver
E. Motorcycle passenger
F. Other _____

Were you wearing a seat belt? (A) Yes (B) No

Other injuries due to this condition: (A) None (B)Yes, explain _____

Please briefly explain the circumstances that led to your condition:

What treatments have you already received for this condition?

A. Medications (list) _____
B. Physical therapy (how many weeks ?) _____
C. Chiropractic care (how many weeks ?) _____
D. Epidural injections: How many injections? _____ When was the last ? _____
E. Other (please list)_____

Since the pain/condition began it: (21)

A. Has improved
B. Has worsened
C. Has stayed the same
D. Comes and goes (fluctuates)

What time of the day is pain most intense? (32)

A. On first arising in the morning
B. During the daytime or while at work
C. At the end of the day before bedtime
D. During the night

What aggravates the pain? (22)

A. Walking
B. Standing
C. Sitting
D. Lying down
E. Activity in general
F. Stooping/bending
G. Nothing in particular
H. Other/comments_____

What makes the pain better?

A. Sitting
B. Lying down
C. Walking
D. Standing
E. Nothing in particular
F. Other/comments_____

Does the pain awaken you from sleep?

A. Never
B. Occasionally
C. Frequently

Does the pain keep you from sleeping?

A. Never
B. Occasionally
C. Frequently

Do you have any difficulty walking? (23)
A. No
B. Yes, can walk unlimited distances
C. Yes, can walk less than a mile
D. Yes, can walk only 1-2 blocks
E. Yes, can walk less than 1 block
F. Yes, non-ambulatory (cannot walk)
G. Other _____

Is walking difficulty related to this condition?
A. Yes
B. No, explain _____

Have you had any problems with bowel, bladder, or sexual functions since this condition began? (24)
A. No
B. Yes: Please explain _____

Have you had a previous back or neck problem? (25)
A. No
B. Yes: Explain _____

Do you exercise regularly? (26)
A. No
B. Yes: How often? _____

PAST MEDICAL/SURGICAL HISTORY

Do you have a history of any of these medical conditions?

Diabetes YES NO
_____Diet controlled
_____Medication controlled
_____Insulin controlled

High blood pressure YES NO

Heart disease YES NO
_____Chest pain/angina
_____Heart attack, Date _____
_____Valve disease

Cancer/Tumor YES NO
What type? _____

Ulcers YES NO

Lung disease including emphysema YES NO

Stroke YES NO
When? _____

Circulation problems YES NO

High cholesterol YES NO

Liver disease YES NO

Kidney disease YES NO

Hepatitis YES NO
Type? _____

Immune disorder YES NO

Seizures YES NO

Eye problems YES NO

Headaches YES NO

Thyroid disorder YES NO

Osteoarthritis (wear and tear) YES NO

Rheumatoid arthritis YES NO

Asthma YES NO

Mental disorder YES NO
Explain _____

Other _____

Have you ever had any neck or back (spine) surgery? (27)

A. No
B. Yes: How many? _____

Please list your previous neck and back (spine) operations.

Date	Place	Surgeon	Procedure
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had any other surgery besides spine?

A. No
B. Yes: Please list below

Date	Procedure
_____	_____
_____	_____
_____	_____
_____	_____

CURRENT MEDICATIONS

A. None
B. Yes: Please list below

Name	Dose	For what problem?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Do you have any Allergies? (28)
A. No known allergies including iodine/contrast dye or shellfish
B. Yes, please list _____

SOCIAL AND FAMILY HISTORY

Marital status: (A) Single (B) Married (C) Divorced (D) Widowed
How many children do you have? _____
What is the highest level of education you have completed?
(A) Some high school (B) High school (C) Trade school (D) College (E) Professional school

Do you smoke? (A) No (B) Yes; packs per day? _____
How many years have you been smoking? _____

Do you smoke a pipe? (A) No (B) Yes How often? _____
Do you smoke cigars? (A) No (B) Yes How often? _____
Do you use smokeless tobacco? (A) No (B) Yes How much? _____

Did you ever smoke regularly before? (A) No (B) Yes; packs per day? _____
How many years did you smoke? _____ When did you quit smoking? _____

How much alcohol do you consume in an average week (beer, wine, etc.)? (29)
A. None
B. Less than 6 drinks
C. 6-12 drinks
D. 12-24 drinks
E. 24-48 drinks
F. More than 48 drinks

What is your current work status? (30)
A. Regular employment - no restrictions
B. Full time with restrictions
C. Part time by choice
D. Part time with restrictions
E. Part time due to a spine problem
F. Part time due to other medical reason, Specify _____
G. Retired by choice
H. Retired due to a spine problem
I. Retired due to other medical reason, Specify _____
J. Unemployed - looking for work with no restrictions
K. Unemployed - looking for light duty work
L. Unemployed
M. Currently not working due to a spine problem
N. Currently not working due to other medical reason, Specify _____
O. Student

Do you have a family history of any of these diseases? (Circle all that are appropriate) (31)

A. None
B. Back or neck problems
C. Cancer
D. Diabetes
E. Heart disease
F. Hypertension
G. Osteoarthritis (wear & tear)
H. Rheumatoid arthritis
I. Scoliosis
J. Stroke
K. Other _____

REVIEW OF SYSTEMS

Have you recently experienced any of the following?

General:

Weight gain	YES	NO
Weight loss	YES	NO
Fever	YES	NO
Chills	YES	NO
Night sweats	YES	NO

Skin:

Change in moles	YES	NO
Breast lumps	YES	NO

Eyes:

Loss of vision	YES	NO
Double vision	YES	NO

ENT:

Hearing loss	YES	NO
Nose bleeds	YES	NO

GI:

Nausea	YES	NO
Vomiting	YES	NO
Change in bowel habits	YES	NO
Heartburn	YES	NO

Respiratory:

Shortness of breath	YES	NO
Coughing/wheezing	YES	NO

Heart:

Chest pain	YES	NO
Palpitations	YES	NO
Fainting	YES	NO

GU:

Frequent urination	YES	NO
Difficulty with urination	YES	NO
Blood in urine	YES	NO

Vascular:

Swelling lower extremities	YES	NO
Emboli (blood clots)	YES	NO

Musculoskeletal:

Muscle weakness	YES	NO
Stiffness	YES	NO
Joint pain	YES	NO

Psych:

Anxiety	YES	NO
Depression	YES	NO
Confusion	YES	NO
Memory loss	YES	NO

Dr. signature _____