

**TUCKAHOE ORTHOPAEDIC ASSOCIATES, LTD.**  
**Spine and Interventional Pain Management**  
**Patient History Form**

Name \_\_\_\_\_ Date \_\_\_\_\_  
Last Name First Name Middle Initial

Address: \_\_\_\_\_  
Street Address City State Zip Code

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex(M or F) \_\_\_\_\_ SSN# \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Emergency Contact \_\_\_\_\_  
Name Relationship  
 \_\_\_\_\_  
Home Phone # Work Phone #

**HISTORY OF PRESENT ILLNESS**

- Chief Complaint** - (Reason for your visit) \_\_\_\_\_
- Check those which best describe the **location** of your symptoms:

<b>Neck Pain</b> <input type="checkbox"/>	<b>Shoulder</b>	<b>Upper Arm</b>	<b>Elbow</b>	<b>Wrist</b>	<b>Forearm</b>	<b>Hand</b>	<b>Fingers</b>
Radiates To	<input type="checkbox"/> R	<input type="checkbox"/> R	<input type="checkbox"/> R	<input type="checkbox"/> R	<input type="checkbox"/> R	<input type="checkbox"/> R	<input type="checkbox"/> R
→	<input type="checkbox"/> L	<input type="checkbox"/> L	<input type="checkbox"/> L	<input type="checkbox"/> L	<input type="checkbox"/> L	<input type="checkbox"/> L	<input type="checkbox"/> L
<b>Back Pain</b> <input type="checkbox"/>	<b>Buttocks</b>	<b>Hip</b>	<b>Thigh</b>	<b>Thigh</b>	<b>Knee</b>	<b>Leg</b>	<b>Foot</b>
Radiates To	<input type="checkbox"/> R	<input type="checkbox"/> R	<input type="checkbox"/> R	<input type="checkbox"/> R	<input type="checkbox"/> R	<input type="checkbox"/> R	<input type="checkbox"/> R
→	<input type="checkbox"/> L	<input type="checkbox"/> L	(Front) <input type="checkbox"/> L	(Back) <input type="checkbox"/> L	<input type="checkbox"/> L	<input type="checkbox"/> L	<input type="checkbox"/> L

*Physician Notes:*

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- Check the **ONE** box below that best describes how your problem started. Then use the space to the right to explain the **ONE** question below the box you checked. Use as much space as needed.

**NO INJURY** (Onset was:  Gradual or  Sudden)  
 Why do you think it started?

**Explanation**

\_\_\_\_\_

**INJURY** (from Accident or Sport **NOT** Work or Auto)  
 Date \_\_\_\_\_, Where and how did it happen?  
 What sport \_\_\_\_\_ School \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**INJURY AT WORK** (Date \_\_\_\_\_)  
 From a  lift  twist  bend  pull  reach

\_\_\_\_\_

\_\_\_\_\_

**WORK RELATED (BUT NO INJURY)**  
 Date \_\_\_\_\_, How did job cause this problem?

\_\_\_\_\_

\_\_\_\_\_

**AUTO ACCIDENT** (Date \_\_\_\_\_) How was car hit?

\_\_\_\_\_

\_\_\_\_\_

4. **Duration** - How long has your problem been present?

- Not Sure     1 Day     3 Days     1 Week  
 Month     3 Months     6 Months     6 Months to 1 Year  
 1-2 Years     2-3 Years     3-5 Years     More than 5 Years

5. **Neck and Arm Pain**- Describe your Pain (Please check only one)

- 100% Neck Pain and 0% Arm Pain  
 75% Neck Pain and 25% Arm Pain  
 50% Neck Pain and 50% Arm Pain  
 25% Neck Pain and 75% Arm Pain  
 0% Neck Pain and 100% Arm Pain

6. **Back and Leg Pain**- Describe your Pain (Please check only one)

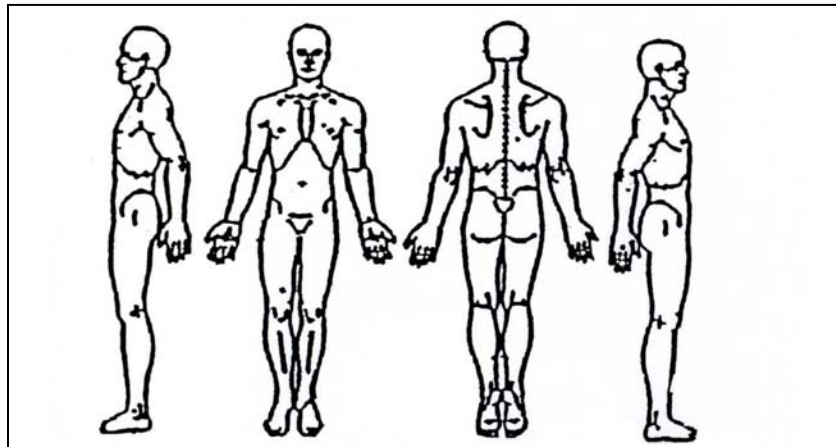
- 100% Back Pain and 0% Leg Pain  
 75% Back Pain and 25% Leg Pain  
 50% Back Pain and 50% Leg Pain  
 25% Back Pain and 75% Leg Pain  
 0% Back Pain and 100% Leg Pain

7. **Description** and Illustration of your symptoms:

- Stinging     Burning     Aching     Tingling  
 Spasm     Coolness     Stabbing     Throbbing  
 Numbness     Tender

8. **Frequency**-  Rarely     Intermittent     Constant

Please mark with an "x" on the drawings where your pain and symptoms are most often located: \*



\* Note: This drawing cannot be marked online. Please mark the "x" on the drawings after you have printed this form.

9. **Severity of Pain** (0 - 10 Scale). Please mark with an x on the scale where your pain is at this time:

0 ----- 10

No Pain

Worst Pain

10. Since your pain **started**, it is:  Getting Better     Getting Worse     Unchanged

11. What makes your symptoms **worse**?

- Driving     Sitting     Coughing     Sneezing     Bearing Down to Have a Bowel Movement  
 Lifting     Exercise     Twisting     Lying in Bed     Bending     Squatting     Kneeling  
 Stairs     Standing     Walking

Physician Notes:

12. What makes it **better**?  Rest     Heat     Ice     Elevation     Other \_\_\_\_\_

13. How long can you **sit** at one time without notable symptoms? \_\_\_\_\_

14. How long can you **stand** without notable symptoms? \_\_\_\_\_ Minutes. **Walk?** \_\_\_\_\_ Minutes

**TREATMENT**

15. What **medications** have you taken *in the past* for this condition? (Please list) \_\_\_\_\_  
\_\_\_\_\_

16. What **medications** are you *currently* taking for this condition? (Please list and **note dosages**)  
\_\_\_\_\_  
\_\_\_\_\_

17. Please list the names of any doctors who have treated you for this condition: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18. Have you had **Surgery for this Condition** in the past?  Yes  No If yes, please list below:

Surgery Performed	Surgeon	Date

19. What **Other Treatments** have you tried for this condition? (Please check those which apply)

**Physical Therapy** - Date \_\_\_\_\_ How long? \_\_\_\_\_ Did you improve? \_\_\_\_\_

**Chiropractic** - Date \_\_\_\_\_ How long? \_\_\_\_\_ Did you improve? \_\_\_\_\_

**Steroid Injections** - Date \_\_\_\_\_ By Whom? \_\_\_\_\_

Type of Injection \_\_\_\_\_ Did you improve? \_\_\_\_\_

**Pain Management**- Date \_\_\_\_\_ Location \_\_\_\_\_

Please describe your treatment \_\_\_\_\_

Did you improve? \_\_\_\_\_

**Psychiatry / Counseling** - Name of Psychiatrist/Counselor \_\_\_\_\_

**Other** (Please describe) \_\_\_\_\_

20. Have you had an MRI, X-rays, CT scan within the last six months?  Yes  No. If yes, please list.

Test Done	Where?	When?

**PAST MEDICAL HISTORY**

21. **CURRENT MEDICATIONS:** Please list **all** medications you are currently taking (including dosages):

MEDICATION	DOSE	MEDICATION	DOSE

Pharmacy \_\_\_\_\_ Address \_\_\_\_\_  
Phone \_\_\_\_\_

22. **ALLERGIES TO** : If yes, please list and describe reaction

List Medication and/or Describe Reaction

Medications  Yes  No

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Shell Fish  Yes  No

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Contrast Dye  Yes  No

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Local Anesthetic  Yes  No

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General Anesthetic  Yes  No

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Latex  Yes  No

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Other  Yes  No

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23. **SURGERIES:** Please list surgeries you have had in the past *other than for your spine condition:*

SURGERY	DATE	SURGERY	DATE

24. **MEDICAL PROBLEMS:**

Please check (✓) any of the following conditions or problems that you have faced at any time in your life:

<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anorexia/Bulimia <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma/COPD <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Cataracts <input type="checkbox"/> Cancer Type: _____ <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes Type: _____ <input type="checkbox"/> Drug Dependency <input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Emphysema <input type="checkbox"/> Glaucoma <input type="checkbox"/> Headaches <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis Type: _____ <input type="checkbox"/> Hernia <input type="checkbox"/> HIV Positive <input type="checkbox"/> Hypertension <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker Implant <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio <input type="checkbox"/> Pregnancy <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Psychiatric Conditions <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Stomach Ulcer <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid Condition	<input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Other (list) _____ _____ _____
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26. REVIEW OF SYSTEMS

Please check (√) any of the following symptoms or problems that you have experienced during the last six (6) months:

<p><b>CONSTITUTIONAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Weight gain</li> <li><input type="checkbox"/> Weight loss</li> <li><input type="checkbox"/> Marked fatigue</li> <li><input type="checkbox"/> Fever</li> <li><input type="checkbox"/> Sweats</li> <li><input type="checkbox"/> Trouble sleeping</li> <li><input type="checkbox"/> Excessive thirst</li> <li><input type="checkbox"/> Heat/Cold intolerance</li> <li><input type="checkbox"/> Depression or other emotional changes</li> </ul>	<p><b>CARDIOVASCULAR</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chest pain / pressure / tightness</li> <li><input type="checkbox"/> Palpitations</li> <li><input type="checkbox"/> Rapid heart rate</li> <li><input type="checkbox"/> Irregular heart rate</li> <li><input type="checkbox"/> Low blood pressure</li> <li><input type="checkbox"/> High blood pressure</li> <li><input type="checkbox"/> Shortness of breath</li> <li><input type="checkbox"/> Poor circulation</li> </ul>	<p><b>GASTROINTESTINAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Persistent/recurring stomach pain</li> <li><input type="checkbox"/> Loss of bowel control ***</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Painful bowel movement</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Blood in stool</li> <li><input type="checkbox"/> Heartburn or indigestion</li> <li><input type="checkbox"/> Nausea/vomiting</li> <li><input type="checkbox"/> Yellow jaundice</li> </ul>
<p><b>MUSCULOSKELETAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Joint pain</li> <li><input type="checkbox"/> Joint stiffness</li> <li><input type="checkbox"/> Joint redness or swelling</li> <li><input type="checkbox"/> Weakness</li> <li><input type="checkbox"/> Cramps</li> </ul>	<p><b>NEUROLOGICAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Headaches</li> <li><input type="checkbox"/> Blackouts/Fainting</li> <li><input type="checkbox"/> Numbness/Paralysis</li> <li><input type="checkbox"/> Seizures</li> <li><input type="checkbox"/> Weakness</li> <li><input type="checkbox"/> Memory loss</li> </ul>	<p><b>RESPIRATORY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Persistent cough</li> <li><input type="checkbox"/> Coughing up blood</li> <li><input type="checkbox"/> Wheezing</li> </ul>
<p><b>EARS, NOSE &amp; THROAT</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Earache or discharge</li> <li><input type="checkbox"/> Loss of hearing</li> <li><input type="checkbox"/> Vertigo/Dizziness</li> <li><input type="checkbox"/> Nosebleeds</li> <li><input type="checkbox"/> Ringing in ears</li> <li><input type="checkbox"/> Sinus problems</li> <li><input type="checkbox"/> Bleeding gums</li> </ul>	<p><b>SKIN</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Frequent bruising</li> <li><input type="checkbox"/> Itching</li> <li><input type="checkbox"/> Rash</li> <li><input type="checkbox"/> Color changes</li> <li><input type="checkbox"/> Nail or hair changes</li> <li><input type="checkbox"/> Hives</li> <li><input type="checkbox"/> Sores that don't heal</li> <li><input type="checkbox"/> Bleeding</li> </ul>	<p><b>GENITOURINARY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Loss of bladder control***</li> <li><input type="checkbox"/> Blood in urine</li> <li><input type="checkbox"/> Painful urination</li> <li><input type="checkbox"/> Urgency to urinate</li> <li><input type="checkbox"/> Loss of bladder control</li> <li><input type="checkbox"/> Frequent urination</li> <li><input type="checkbox"/> Difficulty urinating</li> </ul>
<p><b>WOMEN ONLY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Extreme menstrual pain</li> <li><input type="checkbox"/> Vaginal discharge</li> <li><input type="checkbox"/> Painful intercourse</li> <li><input type="checkbox"/> Breast pain</li> <li><input type="checkbox"/> Nipple discharge</li> <li><input type="checkbox"/> Breast lump – if yes, date of last Mammogram</li> <li><input type="checkbox"/> Pregnant at this time</li> </ul>	<p><b>MEN ONLY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Breast lump</li> <li><input type="checkbox"/> Penis discharge</li> <li><input type="checkbox"/> Sore on penis</li> <li><input type="checkbox"/> Lump on testicle</li> <li><input type="checkbox"/> Other _____</li> </ul>	<p><b>EYES</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Blurred vision</li> <li><input type="checkbox"/> Double vision</li> <li><input type="checkbox"/> Eye pain</li> </ul>
<p><b>PSYCHOLOGICAL HISTORY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Anxiety</li> <li><input type="checkbox"/> Bipolar</li> <li><input type="checkbox"/> Schizophrenia</li> <li><input type="checkbox"/> Personality disorder</li> <li><input type="checkbox"/> History of Suicide Attempt(s)</li> <li><input type="checkbox"/> Thoughts of Suicide Now</li> <li><input type="checkbox"/> Other _____</li> </ul>	<p><b>AMBULATION AIDS</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cane</li> <li><input type="checkbox"/> Walker (standard vs. rolling)</li> <li><input type="checkbox"/> Crutches</li> <li><input type="checkbox"/> Wheelchair</li> </ul>	<p><b>PHYSICIAN'S NOTES</b></p>

FAMILY AND SOCIAL HISTORY

26. **FAMILY HISTORY** Please check (✓) any conditions experienced by your parents, grandparents or siblings:

- High Blood Pressure  
  Diabetes  
  Cancer\*  
  Heart Disease  
  Stroke  
  Back/Neck Pain  
 Rheumatoid Arthritis  
  Stroke  
  Same orthopaedic condition you are being seen for today

\* If Cancer, please indicate type of cancer \_\_\_\_\_.

27. **SOCIAL HISTORY**

- Married  
  Single  
  Separated  
  Widowed  
  Divorced

Number of Children: \_\_\_\_\_ Highest Level of Education: \_\_\_\_\_

Occupation: \_\_\_\_\_ Describe Your Duties \_\_\_\_\_

Employer \_\_\_\_\_ How Long? \_\_\_\_\_

Employer Address \_\_\_\_\_ Phone \_\_\_\_\_

Are you currently out of work due to a work injury?  Yes  No If yes, Last day worked \_\_\_\_\_

Are you receiving Workers' Compensation or Disability  Yes  No

Do you have an attorney related to a workers' compensation case?  Yes  No \_\_\_\_\_

*Attorney's Name*

Do you smoke?  Yes  No If yes, how much? \_\_\_\_\_ If no, when did you quit? \_\_\_\_\_

Do you drink alcoholic beverages?  Yes  No If yes, how often? \_\_\_\_\_

Have you used illicit drugs in the past?  Yes  No If yes, when \_\_\_\_\_

Have you been treated for alcohol or drug dependency in the past?  Yes  No. If yes, where and when? \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**For Physician and Nursing Use**

<u>Height</u>	<u>Weight</u>	<u>Pulse</u>
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**Treatment Plan**

\_\_\_\_\_  
*Physician Signature*

\_\_\_\_\_  
*Date*