INITIAL VISIT QUESTIONNAIRE
FILL THIS OUT BEFORE YOUR APPOINTMENT!!

CENTRAL FLORIDA NEUROSURGERY INSTITUTE MEDICAL HISTORY FORM

ABOUT YOU

Patient Name: .... Today's date: ....

Birth date: .... Age: .... Are you right or left handed? ....

ABOUT YOUR MEDICAL PROBLEMS

List the problems or concerns you want us to address, starting with the most important:
[1] ....
[2] ....
[3] ....

When did the primary problem start (exact date, if possible)? ....

Did it come on: [ ] instantly [ ] over a few hours [ ] over days [ ] other

What brought it on? ....

Are there any activities or positions that significantly worsen your symptoms?
[ ] sitting [ ] standing [ ] walking [ ] lifting [ ] bending [ ] other (list): ....

Are there any activities or positions that significantly improve your symptoms?
[ ] sitting [ ] standing [ ] walking [ ] lifting [ ] bending [ ] other (list): ....

With time, are your symptoms: [ ] improving [ ] staying the same [ ] worsening

Did you ever have any problems in this area of your body before this? [] No [ ]Yes
If yes, please describe: ....
....

PREVIOUS EVALUATIONS

What other doctors, therapists, or chiropractors have you seen for this problem?

Name	Specialty	Approximate date seen

What tests were done?

Name of test and body area studied	Date	Where done	Result, if known
[ ] X-ray of:			
[ ] MRI Scan of:			
[ ] CAT Scan of:			
[ ] Myelogram:			
[ ] Radioactive Bone Scan:			
[ ] EMG:			
[ ] Angiogram			

Patient Name: ______________________________ DOB: ________________
Date: __________

[ ] Blood tests:			

PREVIOUS TREATMENTS

MEDICATIONS

What medications have you tried for this problem? (Medications for other problems will be asked later)

(Write medication name & dose below)	Helped A Lot	Helped A Little	No Effect	Made Worse	Check if you still use this	If no longer using, why not?
	[ ]	[ ]	[ ]	[ ]	[ ]	
	[ ]	[ ]	[ ]	[ ]	[ ]	
	[ ]	[ ]	[ ]	[ ]	[ ]	
	[ ]	[ ]	[ ]	[ ]	[ ]	
	[ ]	[ ]	[ ]	[ ]	[ ]	

PHYSICAL THERAPY	Helped A Lot	Helped A Little	No Effect	Made Worse	Check if you still use this	How many times a month do you still do this?
[ ] Ice / Heat / Ultrasound	[ ]	[ ]	[ ]	[ ]	[ ]	
[ ] Massage	[ ]	[ ]	[ ]	[ ]	[ ]	
[ ] Electrical stimulation	[ ]	[ ]	[ ]	[ ]	[ ]	
[ ] Traction	[ ]	[ ]	[ ]	[ ]	[ ]	
[ ] Exercise	[ ]	[ ]	[ ]	[ ]	[ ]	

CHIROPRACTIC	Helped A Lot	Helped A Little	No Effect	Made Worse	Check if you still go	How many times a month do you still go?
[ ] Manipulation	[ ]	[ ]	[ ]	[ ]	[ ]	

INJECTIONS Area of body injected	Helped A Lot	Helped A Little	No Effect	Made Worse	Physician	Date(s) Injected
	[ ]	[ ]	[ ]	[ ]		
	[ ]	[ ]	[ ]	[ ]		

PAST MEDICAL HISTORY

Have you been diagnosed with any other medical problems? Check all that apply:

[ ] High blood pressure
[ ] Diabetes
[ ] Cancer
[ ] Osteoarthritis
[ ] Rheumatoid arthritis
[ ] Gout
[ ] Thyroid disease
[ ] Osteoporosis
[ ] Migraine headaches
[ ] Stroke or TIA
[ ] Severe head injury
[ ] Brain aneurysm
[ ] Seizures
[ ] Tuberculosis
[ ] Emphysema or asthma
[ ] Heart attack or angina
[ ] Irregular heart beat
[ ] Abnormal heart valve
[ ] Aortic aneurysm
[ ] Poor circulation
[ ] Ulcers in stomach or intestines
[ ] Kidney problems
[ ] Liver problems
[ ] Bowel problems
[ ] Easy bleeding
[ ] Blood clots
[ ] Depression
[ ] Anxiety disorder
[ ] Other mental illness ....
[ ] Addiction to alcohol
[ ] Addiction to other drugs
[ ] HIV/AIDS
[ ] Major trauma (accidents, falls)
[ ] Broken bones
[ ] Prolonged prednisone use
[ ] OTHER: ....

PAST SURGICAL HISTORY

Type of surgery	Why was it done?	Surgeon	Hospital	Date

HOSPITALIZATIONS

Have you been hospitalized for reasons other than the above surgeries?

Reason for Hospitalization	When?

Patient Name: _______________________ _______ DOB: ______________ Date: _______

Patient Name: _______________________ _______ DOB: _______________ Date: _______

MEDICATIONS

What prescription medicines do you take? (List here, or bring a list if you have one).

Name of medicine	What is this for?	Dose and frequency	When did you start taking this?

What non-prescription medicines do you take? **(Include aspirin, if applicable)**

Name of medicine	What is this for?	Dose and frequency	When did you start taking this?

ALLERGIES

Are you allergic to iodine, shellfish, or contrast dye? [ ] No [ ] Yes
Are you allergic to any medicines? [ ] No [ ]Yes If yes, list medicine(s) and the reaction(s):

REVIEW OF SYSTEMS

Check all that you have you had in the last 3 months:

- [ ] Fevers or chills
- [ ] Unexpected weight loss of more than 10 pounds
- [ ] Difficulty sleeping
  - If "YES", how long does it take to fall asleep? ....
  - How many times a night do you awaken? ....
- [ ] Long breathing pauses while sleeping
- [ ] Loss of vision or double vision
- [ ] Difficulty swallowing, smelling, or hearing
- [ ] Swelling in feet or ankles
- [ ] Chest pain or tightness
- [ ] Shortness of breath
- [ ] Coughing or coughing up blood
- [ ] Stomach or belly pain
- [ ] Nausea and/or vomiting
- [ ] Problems with bowel movements:
  - [ ] Constipation
  - [ ] Diarrhea
  - [ ] Accidental bowel movements
  - [ ] Bloody or black stools
- [ ] Problems with urination:
  - [ ] Accidental urination
  - [ ] Inability to urinate
  - [ ] Urge to urinate more frequently than usual
  - [ ] Burning, foul smelling, cloudy or bloody urine
- [ ] Problems with sexual function
- [ ] Leg cramps when walking or at night
- [ ] Skin rashes
- [ ] Depression
- [ ] Frequent headaches
- [ ] Unconsciousness
- [ ] Difficulty talking
- [ ] Poor coordination
- [ ] Difficulty walking
- [ ] Loss of balance / falling
- [ ] Numbness or tingling in arms, forearms, or hands
- [ ] Weakness in arms, forearms, or hands
- [ ] Numbness or tingling in thighs, legs, or feet
- [ ] Weakness in thighs, legs, or feet

If you are female:

Is there any chance you could be pregnant now? [ ]No [ ]Yes
Are your symptoms worsened near your period? [ ]No [ ]Yes [ ] Not applicable

What exercises do you do regularly?

Type of exercise	Minutes each session	How many times a week?

Patient Name: ____________________________ DOB: _____________ Date: ____________

FAMILY HISTORY

What diseases run in your grandparents, parents, siblings, and children?

	Who has or had this?
[ ] Diabetes	
[ ] Cancer	
[ ] Heart disease	
[ ] Stroke	

	Who has or had this?
[ ] Reaction to anesthesia	
[ ]	
[ ]	
[ ]	

SOCIAL HISTORY

Do you use caffeine?	[ ] No, or very rarely [ ] Yes, up to .... cups/cans of caffeinated pop, tea or coffee daily.	
Do you use alcohol?	[ ] No, or very rarely [ ] Yes, up to .... drinks a day at most.	[ ]I used to drink, but quit in ....
Do you smoke?	[ ]No, I have never smoked [ ] I smoke now, ... packs per day. I've smoked for ....years.	[ ]I used to smoke, but quit in ....
Do you chew tobacco?	[ ] No [ ] Yes	

Are you: [ ] single [ ] married [ ] divorced [ ] widowed [ ] other

How many years of school did you complete? .... Occupation: ....

Are there any lawsuits related to your problem? [ ] No [ ] Yes

Are you receiving disability income? [ ] No [ ] Yes

WORK HISTORY (Complete if your problem started at work, or is interfering with work)

Did your symptoms start at work? [ ] No [ ] Yes [ ] Unsure

Is your problem covered by Worker's Compensation? [ ] No [ ] Yes [ ] Unsure

	At the time of your injury	**Now**
Your employer:		
Your job title:		
Hours worked per week:		
Heaviest load you frequently lift at work:		
Heaviest load you ever lift at work:		

If you reduced your work hours, on what date did you reduce your hours? ....

Are you under a doctor's work restrictions for this problem? [ ]No [ ]Yes

If "YES", which physician gave you restrictions? ....

If "YES", exactly what restrictions are you under? ....

....

THANK YOU FOR FILLING OUT THE MEDICAL HISTORY FORM!

X ____ / /

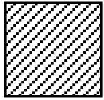
Patient Signature Date

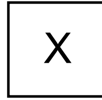
Patient Name: ____ DOB: ___________________ Date:_________

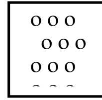
IF YOU HAVE PAIN, TINGLING, AND/OR NUMBNESS, PLEASE COMPLETE BELOW:

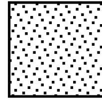
PAIN DIAGRAM

Please draw where you feel your symptoms. Use the appropriate symbols.

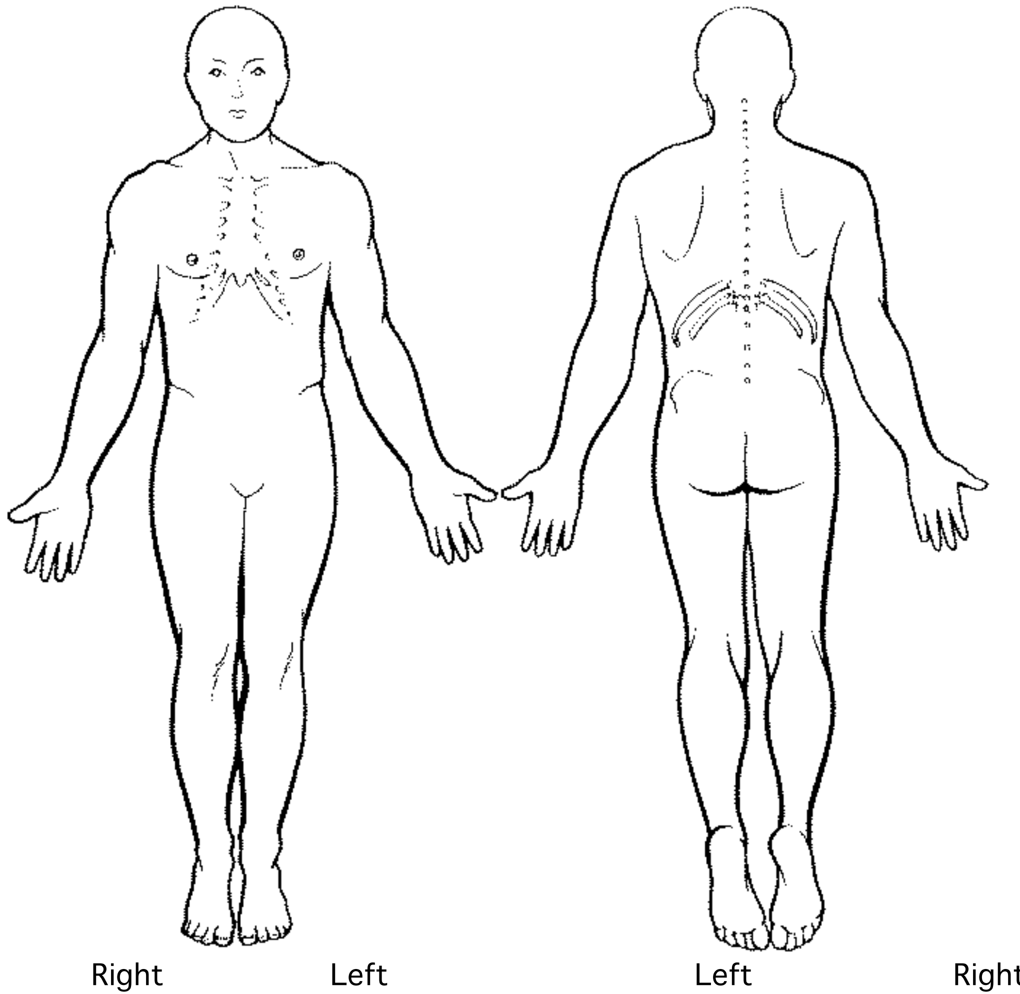








Aching Pain Stabbing Pain Burning Pain Pins & Needles Complete Numbness



Circle how severe your symptoms have been, on average, over the last 2 weeks.

- "0" is no pain at all.
- "10" is severe pain.

Patient Name: ____ DOB: __________________ Date:_________

Neck or Back symptoms 0 1 2 3 4 5 6 7 8 9 10

Arm or leg symptoms 0 1 2 3 4 5 6 7 8 9 10

Least severe Most severe