SPINE & SCOLIOSIS SPECIALISTS
ADVANCED TREATMENT & SURGERY

2105 Braxton Lane, Suite 101 • Greensboro, NC 27408
Phone: (336) 333-6306 • Fax: (336) 333-6309

H&P Medical Form

Name:____

Date of Birth:____________________ Sex: ________Age:________ Date:____________

Primary Care Physician/Medical Doctor:______________________________

List All Drug Allergies/Reactions: ______________________________

❑ If None, Check Here______________________________

List All Medications, Dosages and Frequency Taken:______________________________

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Please Check the Following, Only If Applies To Your Medical History

Neurology

- ❑ Seizures, Last Episode___________
- ❑ Paralysis, Location______________
- ❑ Stroke, When?________________
- ❑ Migraines/Headaches
- ❑ Anxiety/Depression_____________
- ❑ History of Drug/Alcohol Problems__________
- ❑ Mental Disorders_______________
- ❑ Blurred Vision
- ❑ Double Vision
- ❑ Blackout Spells
- ❑ Loss of Memory

Pulmonary

- ❑ Asthma, Last Attack_____________
- ❑ Bronchitis, When?_______________
- ❑ Pneumonia, Last Episode_________
- ❑ COPD/Emphysema
- ❑ T.B.
- ❑ Shortness of Breath
- ❑ Cough
- ❑ Coughing up Blood

Cardiovascular

- ❑ Hypertension/High Blood Pressure
- ❑ Coronary Vessel Disease
- ❑ Myocardial Infarction/Heart Attack__________
- ❑ Congestive Heart Failure__________________
- ❑ Heart Murmur
- ❑ Peripheral Vascular Disease
- ❑ Rheumatic Heart Disease
- ❑ Aneurysms, Where?_________
- ❑ Angina/Chest Pain
- ❑ Difficulty Breathing While Lying Flat
- ❑ Shortness of Breath During Exertion

Gastrointestinal

- ❑ Hiatal Hernia
- ❑ Reflux Disease
- ❑ Ulcers
- ❑ Gastritis
- ❑ Diverticulitis
- ❑ Ulcerative Colitis or Crohn's Disease
- ❑ Hemorrhoids
- ❑ Liver Disease, Describe__________________
- ❑ Gallbladder Disease/Stones
- ❑ Hepatitis, What Kind?_________________
- ❑ Nausea/Vomiting
- ❑ Diarrhea/Constipation
- ❑ Blood or Mucus in Stool
- ❑ Recent Loss of Appetite
- ❑ Jaundice

Genitourinary

- ❑ Prostate Disease, Describe________________
- ❑ Urinary Tract Infections
- ❑ Cystitis
- ❑ Urinary Incontinence
- ❑ Kidney Stones, When/How Many?__________
- ❑ Kidney Failure
- ❑ Pain with Urination
- ❑ Blood in Urine
- ❑ Urinary Discharge
- ❑ Urinary Frequency
- ❑ Weak Stream
- ❑ Urgency
- ❑ Trouble with Excessive Urinating at Night

Endocrine/Glandular

- ❑ Diabetes, Insulin/Non-Insulin______________
- ❑ Thyroid Disease, Describe________________
- ❑ Pancreatic Disease, Describe______________
- ❑ Unusual Increase in Appetite
- ❑ Unusual Increase in thirst
- ❑ Temperature Intolerance
- ❑ Unusual Increase in number of times urinating

Hematology/Oncology

- ❑ Anemia, Any Transfusions________________
- ❑ Bleeding Tendencies, Explain______________
- ❑ Blood Clots, Where?____________________
- ❑ Sickle Cell Anemia
- ❑ Cancers, What Type(s)?__________________
- ❑ HIV/Aids
- ❑ Bleeding Difficulty/Disorders
- ❑ Unusual Fatigue
- ❑ Easily Bruised

Orthopaedic

- ❑ Osteoporosis
- ❑ Broken Bones/Fractures__________________
- ❑ Arthritis, What Kind?____________________
- ❑ Degenerative Disc Disease, Where?_________
- ❑ Joint Pain
- ❑ Joint Swelling
- ❑ Morning Joint Stiffness

Gynecologic

- ❑ Menopause
- ❑ Are you or could you be Pregnant?__________
- ❑ Ovarian Disease, Explain__________________
- ❑ Uterine Fibroids or Disease_______________
- ❑ Breast Disease, Explain_______________
- ❑ Hot Flashes
- ❑ Hormonal Treatments

List & Date All Surgeries: ____

____

____

____

Family History: Please check any family history that applies and list family member and age.

- ❑ Heart Disease____________________________
- ❑ Hypertension____________________________
- ❑ Diabetes________________________________
- ❑ Cancer, What Kind?_______________________
- ❑ Stroke_________________________________
- ❑ Arthritis________________________________
- ❑ Bleeding Disorders_______________________
- ❑ Other__________________________________

Social History:

Marital Status____

Occupation____

Smoker/How much daily?____________________________________

Alcohol/How much daily?____________________________________

Children/How many?_______________________________________

Caregiver After Surgery?____________________________________

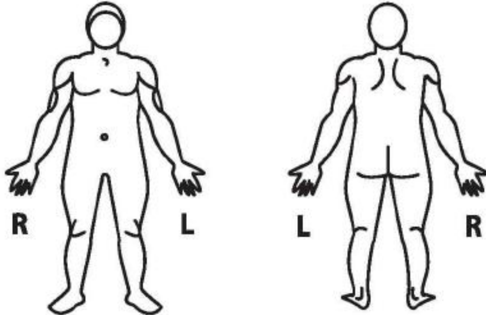
Does your Caregiver work?___________________________________

SPINE & SCOLIOSIS SPECIALISTS
ADVANCED TREATMENT & SURGERY

Surgical and Nonsurgical Intervention

FOLLOW-UP ASSESSMENT

Name: ____________ DOB: ____________ Primary Care Physician: ____________ Date: ____________

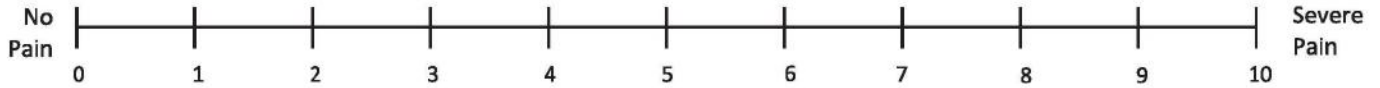


1. Please shade in only the area(s) of your pain that we are **seeing you for today.**

2. Status of pain since your last visit here:
❒ Worse ❒ Better ❒ Same

3. Frequency: ❒Constant ❒Comes/Goes ❒Rarely

4. Please indicate your level of pain:



5. Check the words that best describe the pain for which you are being seen:
❒Aching ❒Burning ❒Dull ❒Numbing ❒Sharp
❒Cramping ❒Radiating ❒Stabbing ❒Stinging ❒Tingling

6. Please indicate which (if any) treatments you've had for the condition for which we are seeing you today.
❒Physical Therapy ❒Chiropractic Care ❒Medications ❒Massage ❒Injections*

*If yes to Injections, did you get relief? ❒Yes ❒No If yes, what percentage of relief? _______%
If yes, for how long? _______ minutes _______ hours ________ days ________ weeks _______ months

7. Are you working? ❒Full Duty ❒Light Duty ❒Not Working

8. Since your last visit here, have you seen your Primary Care Physician, been hospitalized or had surgery?
➢ If yes, please explain:

____

____

9. Please check the activities that increase, decrease or do not change the pain for which we are treating you

ACTIVITY	INCREASE PAIN	DECREASE PAIN	NO CHANGE
Sitting	❒	❒	❒
Standing	❒	❒	❒
Walking	❒	❒	❒
Lying Down	❒	❒	❒
Changing Positions	❒	❒	❒
Leaning Forward	❒	❒	❒

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10. Mark the following signs and/or symptoms you experience: If none apply, please check: ❐ None of these apply to me.

Constitutional
- ❐Chills
- ❐Fatigue
- ❐Fever
- ❐Night Sweats
- ❐Weakness
- ❐Weight Gain
- ❐Weight Loss

Cardiovascular
- ❐Chest Pain
- ❐Heart Murmur
- ❐Leg Swelling
- ❐Syncope
- ❐Irregular Heartbeat/Palpitations

Metabolic/Endocrine
- ❐Cold Intolerant
- ❐Hair Loss
- ❐Heat Intolerant

Integumentary
- ❐Contact Allergies
- ❐Itchy Skin
- ❐Rash
- ❐Skin Infections
- ❐Skin Lesions

Hematologic
- ❐Bleeding
- ❐Bruising

HEENT
- ❐Blurred Vision
- ❐Double Vision
- ❐Difficulty/Pain Swallowing
- ❐Ear Drainage
- ❐Facial Pain
- ❐Headache
- ❐Hearing Loss
- ❐Hoarseness
- ❐Nasal Congestion
- ❐Ringing in Ears
- ❐Vertigo
- ❐Vision Loss

Gastrointestinal
- ❐Abdominal Pain/ Constipation
- ❐Black Tarry Stools
- ❐Diarrhea
- ❐Heartburn
- ❐Jaundice
- ❐Loss of Appetite
- ❐Nausea
- ❐Vomiting

Neurological
- ❐Difficulty Walking
- ❐Dizziness
- ❐Poor Coordination
- ❐Memory Loss
- ❐Muscle Weakness
- ❐Seizures
- ❐Tremors

Respiratory
- ❐Chest Pain (Respiratory)
- ❐Cough
- ❐Difficulty/Pain Breathing
- ❐Recent Infections
- ❐Known TB Exposure
- ❐Wheezing

Genitourinary
- ❐Pain with Urination
- ❐Frequent Urination
- ❐Blood in Urine
- ❐Urge Incontinence
- ❐Urinary Incontinence

Psychiatric
- ❐Anxiety
- ❐Depression
- ❐Insomnia

Immunological
- ❐Asthma
- ❐Bee Sting Allergy
- ❐Environmental Allergies
- ❐Food Allergies
- ❐Seasonal Allergies
- ❐Latex Allergy

11. Have you been admitted to the hospital for any reason in the last 30 days? ❐Yes ❐No
    - ➢ Discharge Date: ____________________
    - ➢ Diagnosis: ____________________
12. Do you take blood thinners (including aspirin)? ❐Yes ❐No If yes, medication: ____________________
    - ➢ Diagnosis: ____________________
13. Have you ever used tobacco products: ❐Yes ❐No Status: ❐Current User ❐Former User
14. Do you take medications for osteoporosis (brittle bones)? ❐Yes ❐ No If yes, medication: ____________________
15. Do you take medications for high blood pressure? ❐Yes ❐ No If yes, medication: ____________________
16. Have you received an influenza vaccine (flu): ❐Yes ❐No Date: ____________ Best Estimate: ____________
17. Have you received a pneumonia vaccine? ❐Yes ❐No Date: ____________ Best Estimate: ____________
18. Have you fallen in the last year? ❐Yes ❐No # of falls: ____________ Did it result in injury? ❐Yes ❐No

Name: ______________________________ Date: ____________________

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Family Hx Dx:	❐Mother	❐Father	❐Sister	❐Brother	Dx: ____________
Is pt. post op SSS?	❐Yes	❐No	❐Surgery: ____________		
Assistive device?	❐Cane	❐Walker	❐Rolling Walker		❐Other

Provider:

50+ Does pt. have hip, spine/radius fx today? ❐Yes ❐No
If yes, refer to PCP, Dr. ____________________ for treatment of osteoporosis.

65+ Is pt. at risk for falls? ❐ Yes ❐ No
Balance/Strength/ Gait Training (*circle*) Advised PT Declined PT Home PT HEP N/A Other: ____________

❐Address BMI:	❐Did not counsel	❐Child BMI	❐Underweight
❐Hypertension >120/80:	❐Diet	❐Activity	❐Referral

____
Tech:

First name: ______________________ Last name: ____________________________ Date of birth:______________

The following questions ask for your views about your health—how you feel and how well you are able to do your usual activities. All kinds of people across the country are being asked these same questions. Their answers and yours will help to improve health care for everyone. There are no right or wrong answers; please choose the answer that ***BEST FITS YOUR LIFE RIGHT NOW.***

Answer each question by checking the best response.

In general, would you say your health is: ❒ Excellent ❒ Very good ❒ Good ❒ Fair ❒ Poor

The following questions are about activities you might do during a typical day. Does your health not limit you in these activities? If so, how much?	Yes Limited a lot	Yes Limited a little	No Not limited at all
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf?	❒	❒	❒
Climbing several flights of stairs?	❒	❒	❒

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?	No None of the time	Yes A little of the time	Yes Some of the time	Yes Most of the time	Yes All of the time
Accomplished less than you would like:	❒	❒	❒	❒	❒
Were limited in the kind of work or other activities:	❒	❒	❒	❒	❒

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?	No None of the time	Yes A little of the time	Yes Some of the time	Yes Most of the time	Yes All of the time
Accomplished less than you would like:	❒	❒	❒	❒	❒
Didn't do work or other activities as carefully as usual:	❒	❒	❒	❒	❒

During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

❒ Not at all ❒ A little bit ❒ Moderately ❒ Quite a bit ❒ Extremely

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks	All the time	Most of the time	A good bit of the time	Some of the time	A little of the time
Have you felt calm and peaceful?	❒	❒	❒	❒	❒
Did you have a lot of energy?	❒	❒	❒	❒	❒
Have you felt downhearted and blue?	❒	❒	❒	❒	❒

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

❒ All of the time ❒ Most of the time ❒ Some of the time ❒ A little of the time ❒ None of the time

Now, we'd like to ask you some questions about how your health may have changed.

Compared to one year ago:	Much better	Slightly better	About the same	Slightly worse	Much worse
How would you rate your physical health in general now:	❒	❒	❒	❒	❒
How would you rate your emotional problems:	❒	❒	❒	❒	❒

Your answers are important!

Thank you for completing this questionnaire!