SPECIALTY ORTHOPAEDICS, PLLC
Westchester Spine Institute
Cristian Brotea, M.D.
PATIENT SPINE QUESTIONNAIRE

Patient Name _____
Date ____/_____/_____

REFERRING PHYSICIAN NAME: _____ **Shall we sent report to him/her**: YES ◊ NO ◊

WHAT IS THE CHIEF PROBLEM THAT BRINGS YOU TO SEE DR. BROTEA? _____

_____

How long have you had the problem? #____ DAYS ◊ WEEKS ◊ MONTHS ◊ YEARS ◊

Which is worse? BACK ◊ LEG ◊ ARM ◊ BACK AND LEG PAIN ARE EQUAL ◊ NECK AND ARM PAIN ARE EQUAL ◊

Problem is: CONSTANT ◊ INTERMITTENT ◊ **and** GETTING WORSE ◊ GETTING BETTER ◊ STAYING THE SAME ◊

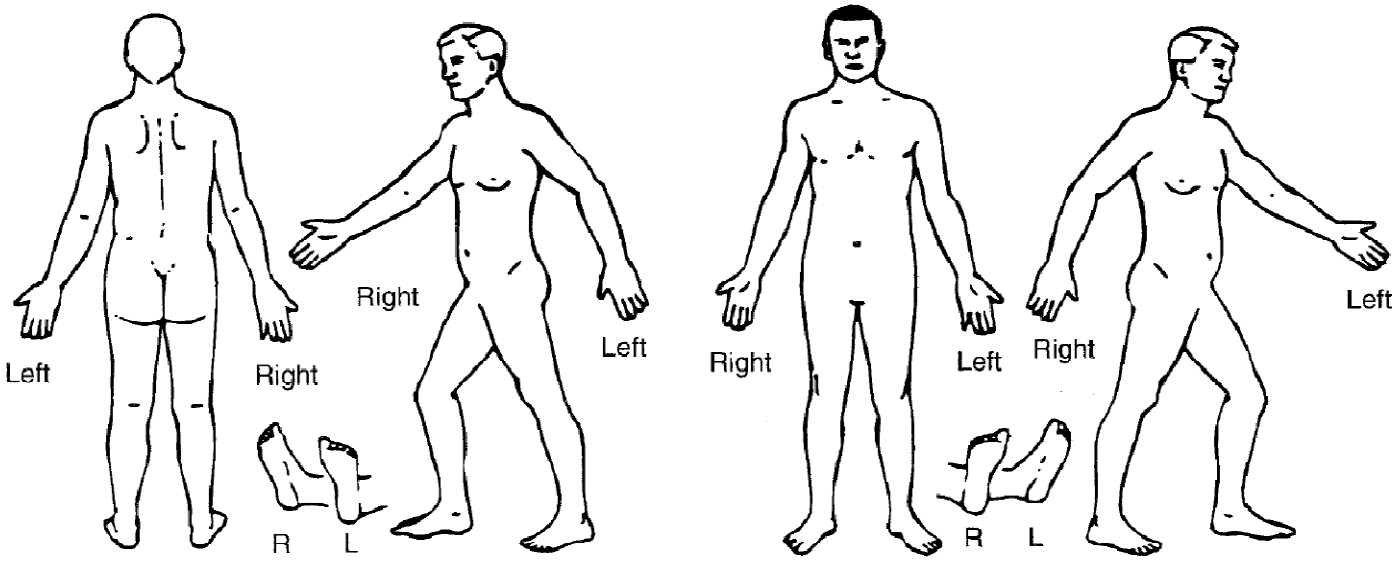
Cause of your problem? WORK INJURY ◊ CAR ACCIDENT ◊ SPORTS INJURY ◊ FALL ◊ NO SPECIFIC INJURY ◊ OTHER ◊

Description of incident: _____

Rate your pain with an 'X': **0/10** (no pain**) ----------10/10** (severe)

Mark in the areas of your body where you now feel your typical pain. Include all affected areas. Use the appropriate symbols indicated below:

ACHE >>>> NUMBNESS ------ PINS & NEEDLES oooo BURNING xxxx STABBING ////



Which of the following increase your pain? EXERCISE ◊ SITTING ◊ STANDING ◊ WALKING ◊ LIFTING ◊ TWISTING ◊ BENDING BACKWARDS ◊ COUGHING ◊ SNEEZING ◊ SLEEPING ◊ WALKING UP STAIRS ◊ WALKING DOWN STAIRS ◊

Other _____

Which of the following decrease your pain? Lying down ◊ Sitting ◊ Standing ◊ Walking ◊ Leaning forward ◊

Other _____

Medications for this problem: Pain Pills (vicodin/percocet/nucynta) ◊ Other_____

Muscle Relaxants (flexeril/skelaxin) ◊ Other _____

Anti-inflammatories (ibuprofen/advil/aleve/naproxen/mobic/celebrex) ◊ Other _____

Have you tried any physical therapy/chiropractor care for these symptoms? YES ◊ NO ◊ **How long** _____

Have you had any injections? YES ◊ NO ◊ **How many**? _____ **When was the last one**? _____

Have you had any of the following symptoms?

Chest Pain	YES ◊	NO ◊	Dizziness	YES ◊	NO ◊
Dry Cough	YES ◊	NO ◊	Irregular Heartbeat	YES ◊	NO ◊
Productive Cough	YES ◊	NO ◊	Difficulty Breathing	YES ◊	NO ◊
Swelling in the legs	YES ◊	NO ◊	Lack of appetite	YES ◊	NO ◊
Diarrhea	YES ◊	NO ◊	Abdominal Cramping	YES ◊	NO ◊
Nausea/Vomiting	YES ◊	NO ◊	Varicose Veins	YES ◊	NO ◊
Bruising	YES ◊	NO ◊	Bleeeding	YES ◊	NO ◊
Nose Bleeds	YES ◊	NO ◊	Joint Pain/Stiffness	YES ◊	NO ◊
Muscle Pain/Cramps	YES ◊	NO ◊	Difficulty Seeing	YES ◊	NO ◊
Difficulty Hearing	YES ◊	NO ◊	Constipation	YES ◊	NO ◊

Any medical problems? PHLEBITIS / **BLOOD CLOTS / BLEEDING PROBLEMS** ◊ ASTHMA ◊ STROKE ◊ **DIABETES** ◊

THYROID DISEASE ◊ HIGH BLOOD PRESSURE ◊ **HEART DISEASE** ◊ **ULCER** ◊ HEPATITIS ◊ (type _____)

GOUT ◊ TB ◊ **CANCER** ◊ (type _____) RADIATION/CHEMO ◊ HEADACHES ◊ DEPRESSION ◊

RHEUMATOID ARTHRITIS ◊

Other _____

Do you have any BALANCE PROBLEMS: YES ◊ NO ◊ since the onset of pain? YES ◊ NO ◊

Do you have problems passing your urine? YES ◊ NO ◊ since the onset of pain? YES ◊ NO ◊

Do you have constipation? YES ◊ NO ◊ since the onset of pain? YES ◊ NO ◊

BOWEL or BLADDER INCONTINENCE (lack of control)? YES ◊ NO ◊

What medications do you take:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

Others _____

Allergies: (or reactions to medicines and other substances – and TYPE of reaction)

_____

Surgical History (type of surgery, location, surgeon name):

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Others _____

Previous SPINE Surgery? YES ◊ NO ◊ **When** _____

What type: CERVICAL ◊ THORACIC ◊ LUMBAR ◊ DISCECTOMY ◊ FUSION (SCREWS/RODS) ◊

Surgeon Name: _____ **Hospital**: _____

Height: _____ **Weight**: _____ lbs

TOBACCO: Have you ever smoked? YES ◊ NO ◊ For how long? _____ If stopped, when? _____

How much do you smoke (cigarettes/packs) _____ **(#/day)**

ALCOHOL: YES ◊ NO ◊ Amount: _____ (#/week)

Have you had any RECENT? Weight gain _____ Weight loss _____ **Fever/sweats at night?** YES ◊ NO ◊

Do you exercise on a regular basis? YES ◊ NO ◊ **Type of exercise**: WALKING ◊ JOGGING ◊ GYM ◊ OTHER ◊

Primary Occupation _____ **Work Status**: working ◊ not working ◊ disabled ◊ retired ◊

If not working, last date you worked **_____/_____/_____**

I hereby acknowledge that the information provided above is current, accurate, and complete to the best of my knowledge. I understand that it will become part of my permanent medical record. I will inform you of any changes to the above information.

Patient or Guardian Signature **_____** ***Date*** **_____**

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS QUESTIONNAIRE.