

SPINAL AND HEALTH HISTORY

LYERLY NEUROSURGERY

Name _____ Age _____ Height _____ Weight _____

Referred by _____ Family Physician _____

Reason for visit today _____

Current problem is the result of a(n): **Check all that apply**

_____ car accident _____ work accident _____ accident _____ other _____

Date of first episode of pain: _____

Date of injury or accident, (if applicable): _____

Any back or neck trouble before injury? Yes _____ No _____

Describe what caused the onset of your pain _____

What makes your pain decrease? _____

What makes your pain increase? _____

Is the pain better, the same or worse than one month ago? _____

Does the pain increase with coughing or sneezing? Yes _____ No _____

Have you had:	YES	NO
bowel control changes	_____	_____
bladder control changes	_____	_____
weakness of legs or feet	_____	_____
numbness of legs or feet	_____	_____

Have you had:	YES	NO	Has it helped:	YES	NO
bedrest	_____	_____		_____	_____
traction	_____	_____		_____	_____
PT exercise	_____	_____		_____	_____
chiropractic manipulation	_____	_____		_____	_____
spine injection	_____	_____		_____	_____
anti-inflammatory meds	_____	_____		_____	_____
pain meds	_____	_____		_____	_____

Have you had:	YES	NO	WHEN
Spine x-rays	_____	_____	_____
CT scan	_____	_____	_____
MRI	_____	_____	_____
Bone scan	_____	_____	_____
EMG	_____	_____	_____
Myelogram	_____	_____	_____

Circle one: I am right handed left handed

Current Medications:

ALLERGIES

Social History

Occupation: _____

Marital Status: Single Married Divorced Widowed

Do you have children? Yes No How many? _____

Do you live alone? Yes No Who lives with you? _____

Do you smoke? Yes, I've smoked _____ packs of cigarettes per day for _____ years.

Yes, I smoke cigars or a pipe.

No, I have never smoked.

No, I quit _____ years ago. At that time I was smoking _____ packs per day for _____ years.

Do you drink alcohol? No, never (or rarely) No, but I used to

Yes Daily 1 or more times a week 1 or more times a month

Are you at risk for AIDS (e.g. sexual orientation, drug abuse, previous blood transfusion?)

No Yes, please explain: _____

Past History

Please list any prior major illnesses and/or injuries:

Surgeries/Hospitalizations	Year	Complications

Have you ever had problems with anesthesia? Yes No

Family Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		