

# Patient Registration Form - SPINE

(PLEASE PRINT IN BLACK INK, AND ANSWER ALL QUESTIONS)

CHART#

DATE

DOCTOR

IS THIS PROBLEM A PERSONAL INJURY OR WORK RELATED? IF YES, STOP AND INFORM RECEPTIONIST.

NAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ APT# \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
CITY \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
STATE \_\_\_\_\_ ZIP \_\_\_\_\_ EMAIL \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ OCCUPATION BEFORE RETIREMENT \_\_\_\_\_  
 MALE  FEMALE SOCIAL SECURITY # \_\_\_\_\_

SECOND ADDRESS \_\_\_\_\_  
NAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ APT# \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

GUARDIAN OR EMERGENCY CONTACT:  
NAME \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
ADDRESS \_\_\_\_\_ PHONE # \_\_\_\_\_  
CITY \_\_\_\_\_ RELATION \_\_\_\_\_

PRIMARY INSURANCE:  
MEDICARE PATIENTS: MEDICARE # \_\_\_\_\_ (IS MEDICARE PRIMARY INS?  YES  NO)  
INSURANCE CO. \_\_\_\_\_ PHONE # \_\_\_\_\_  
ADDRESS \_\_\_\_\_ POLICY / ID # \_\_\_\_\_  
CITY \_\_\_\_\_ GROUP # \_\_\_\_\_  
STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SECONDARY INSURANCE: RELATION TO INSURED: SELF SPOUSE CHILD OTHER  
INSURANCE CO. \_\_\_\_\_ POLICY OWNER'S NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_ POLICY OWNERS SS # \_\_\_\_\_  
CITY \_\_\_\_\_ PHONE # \_\_\_\_\_  
STATE \_\_\_\_\_ POLICY / ID # \_\_\_\_\_

CHECK ONE: HMO  PPO  DID YOU BRING A REFERRAL SLIP?  YES  NO  
GETTING TO KNOW YOU: HOW DID YOU HEAR ABOUT THE FLORIDA KNEE AND ORTHOPEDIC CENTERS?

Attended Seminar  Referred by our patients  Referred by Physician  
 Other  
NAME AND ADDRESS OF YOUR PRIMARY CARE DOCTOR OR FAMILY DOCTOR: \_\_\_\_\_

CARDIOLOGIST \_\_\_\_\_ PHONE \_\_\_\_\_ /FAX \_\_\_\_\_  
PHONE \_\_\_\_\_ /FAX \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

HEIGHT \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_

WEIGHT \_\_\_\_\_

Please state, in your own words, what it is that brings you in today  
\_\_\_\_\_

What are your expectations of today's visit?  
\_\_\_\_\_  
\_\_\_\_\_

How did your present symptoms begin?  Auto accident  Work injury  Other  
\_\_\_\_\_

As best you can recall, what was the date of the injury or painful event?  
\_\_\_\_\_

Please list all the medications which you are taking for your spinal condition  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any symptoms prior to the injury/painful event?  Yes  No  
If yes, please describe \_\_\_\_\_  
\_\_\_\_\_

Is there an attorney involved in your case?  Yes  No

If yes please list attorneys name and address. \_\_\_\_\_  
\_\_\_\_\_

Have you been treated for this condition prior to today's visit?  Yes  No

- Have you had Emergency room visit ?  Yes  No
- Have you been treated with any medications ?  Yes  No
- Have you had spinal injections (epidural steroids etc.)?  Yes  No
- Have you had a spinal MRI ?  Yes  No
- Have you had a Myelogram or myelo/CT  Yes  No
- Have you had a CAT scan ?  Yes  No

Since the initial injury or symptom onset, my symptoms are (check one)  
 Worse     Better     About the same.

I would describe the pain as (check all applicable)  
 Dull     Sharp     Aching     Burning     Stabbing.

Does your pain move from your back into your legs?  Yes     No  
My spinal condition (choose one)

- Prevents me from driving
- Significantly limits my driving
- Does not limit my driving

I can walk, before stopping about

- less than 50 feet
- between 50 feet and 200 feet
- more than 200 feet but less than a block
- between 1 and 3 blocks
- more than 3 blocks but less than a mile
- at least a mile
- as far as I like.

I have numbness or tingling in my

- Right leg
- Left leg
- Right arm
- Left arm

My pain is (X each response)	Better	Worse	Same
sitting	_____	_____	_____
standing	_____	_____	_____
walking	_____	_____	_____
Bending forward	_____	_____	_____
Bending backward	_____	_____	_____
At midday	_____	_____	_____
At night	_____	_____	_____
Lying flat	_____	_____	_____

Have you had any prior surgery on your back or neck?  Yes  No.

If yes, please list procedures and when they were performed:

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The next question is a bit difficult, but answer as best you can

On a scale of zero to ten, with zero being no pain and ten being the worst pain you can imagine, how bad is the pain in your back (one number please) ? \_\_\_\_\_

On the same scale how bad is the pain in your right leg ? \_\_\_\_\_

On the same scale how bad is the pain in your left leg ? \_\_\_\_\_

Give a ratio of two numbers that add to 100, that describe the ratio of the pain in your back to pain in your legs. For example 75/25 would be 75% back pain and 25% leg pain. \_\_\_\_\_ % back %/legs \_\_\_\_\_.

### WORK STATUS

Usual Occupation \_\_\_\_\_

Have you missed work because of your symptoms?  Yes  No

If so please give dates of work missed: \_\_\_\_\_

Have you changed jobs or modified your work because of your symptoms?  Yes  No

If so please explain: \_\_\_\_\_

Are you presently receiving disability pay or are you considered permanently disabled?  Yes  No

If so, please explain \_\_\_\_\_

In the remaining space, please add anything else you wish to.

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REVIEW OF SYSTEMS

Please check items if you have ever had:

Heart and circulation problems:  None.

- High blood pressure
- Low blood pressure
- Heart attack or coronary

At what age \_\_\_\_\_

- Chest pain or angina lasting more than one minute
- Any cardiac arrhythmia or irregular heartbeat

Type \_\_\_\_\_

- Heart failure/Cardiomyopathy
- Heart murmur /Valvular heart disease

Which valve \_\_\_\_\_

- Being awakened from sleep by coughing or shortness of breath
- Blood clot in the lung
- Phlebitis( blood clot in the leg)
- Difficulty walking up two flights of steps (getting short of breath)

Have you ever had cardiac tests

Stress test When: \_\_\_\_\_ Where: \_\_\_\_\_

Echocardiogram When: \_\_\_\_\_ Where: \_\_\_\_\_

Catherization/Coronary Stent/Angioplasty

When: \_\_\_\_\_ Where: \_\_\_\_\_ Where: \_\_\_\_\_

Open-heart surgery When: \_\_\_\_\_ Where: \_\_\_\_\_

Lung or breathing problems:  None.

- Shortness of breath or any difficulty breathing
- Any breathing problem which interfered with normal activity

Do you use oxygen

Do you bring up anything when you cough

Asthma or wheezing

Emphysema/COPD/Bronchitis

Do you have sleep apnea

An abnormal chest x-ray

A cold at this time \_\_\_\_\_

Muscle or joint problems:  None.

Unusual muscle weakness

Back or neck problems

Any limited movement in your neck or jaw

Any treatment for sciatica \_\_\_\_\_

Neurological problems:  None.

Stroke

Epilepsy or seizures

# per month: \_\_\_\_\_

Frequent headaches or migraines

Paralysis

Dizziness or fainting

An arm or leg that becomes numb or weak frequently

Any treatment by a psychiatrist

Gastrointestinal problems:  None.

Vomiting of blood

Stomach pain or been treated for an ulcer

Bloody or black stools

Jaundice or hepatitis

Cirrhosis or enlarged liver

Urinary tract or reproductive problems:  None.

Painful burning during urination or frequent urination

Kidney or bladder infection

Prostate problems

Kidney stone

Blood in the urine

Any kidney disease

Could you be pregnant?

Start date of last menstrual period \_\_\_\_\_

Are you on dialysis \_\_\_\_\_

Metabolic and blood problems:  None.

Diabetes

Do you take insulin

How much \_\_\_\_\_

Anemia

Easy bleeding / poor blood clotting

Frequent or large nosebleeds

Sickle Cell disease

Blood transfusions

Do you take cortisone or steroids

How much \_\_\_\_\_

Eye, ear, nose and throat problems:  None.

Glaucoma or other eye problems

Any serious mouth, throat or larynx (voice box) problem

Any nose or jaw surgery

When: \_\_\_\_\_

Where: \_\_\_\_\_

Any false teeth, caps, bridges, loose or chipped teeth, crowns, braces

Any contact lenses

Any difficulty hearing

Other health questions .  None.

Significant weight loss in the past 4 months without dieting?

Loss of appetite?

Cancer or other tumors or growths?

Treatment for depression?

Any history of skin changing color or of allergy after contact with jewelry or other metal?

Are you under the treatment of any specialists?

Are you feeling extremely anxious about pending surgery.

Knee

PAST MEDICAL HISTORY

Illnesses

Please list any other non-surgical illnesses you have had requiring hospitalization or repeated visits to your doctor and give dates:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PAST SURGICAL / ANESTHESIA HISTORY

Have you ever had any anesthesia or surgery? If so, list surgery and approximate dates:

\_\_\_\_\_  
\_\_\_\_\_

Have you had any problems with prior anesthetics including nausea and vomiting?  Yes  No  
If any problems, please describe:

- Waking up
- Putting in breathing tube
- Other

Have any of your blood relatives had any problems with anesthesia, including high fever?  Yes  No

Are you allergic to local anesthesia such as xylocaine? \_\_\_\_\_ Novocaine? \_\_\_\_\_

Have you had prolonged bleeding after tooth extraction or any bleeding problems?  Yes  No

Do you have problems with your neck or jaw?  Yes  No

Current medications

Are you taking any medications?  Yes  No

If yes, please list medication names and dose. Please include over the counter medicines and vitamin or herb supplements:

1. \_\_\_\_\_ 5. \_\_\_\_\_
2. \_\_\_\_\_ 6. \_\_\_\_\_
3. \_\_\_\_\_ 7. \_\_\_\_\_
4. \_\_\_\_\_ 8. \_\_\_\_\_

Allergies

Please check if allergic to any of these drugs:

- Penicillin
- Sulfa
- Codeine
- Iodine
- Novocaine
- Latex or Rubber

Describe your reaction to the medication: \_\_\_\_\_  
\_\_\_\_\_

Any other drug reactions or allergies to any other medicines? If so, please list and describe reaction:

\_\_\_\_\_  
\_\_\_\_\_

Do you have asthma? Yes \_\_\_\_\_ No \_\_\_\_\_

Knee

**SOCIAL AND FAMILY HISTORY**

- Married
- Single
- Widowed
- Divorced

1. \_\_\_\_\_ Did any of your blood relatives have a heart attack or coronary? At what age? \_\_\_\_\_
- \_\_\_\_\_ Did any of your blood relatives have rheumatoid arthritis or osteoarthritis?
- \_\_\_\_\_ Did any of your relatives have problems with anesthesia, including fever?

Mother  Living  Deceased Cause of death \_\_\_\_\_ Age: \_\_\_\_\_

Father  Living  Deceased Cause of death \_\_\_\_\_ Age: \_\_\_\_\_

Health care providers are required by some insurance companies to ask their patient if they have a living will.  Yes  No If yes, please provide us with a copy.

Do you live alone?  Yes  No

Do you have children?  Yes  No If yes, how many? \_\_\_\_\_

Exercise?  Daily  2-3 x week  Other \_\_\_\_\_

What type of exercise? \_\_\_\_\_

Are you on a special diet?  Yes  No

Describe \_\_\_\_\_

Recreational drug use?  Yes  No

Which type \_\_\_\_\_ When last used? \_\_\_\_\_

Currently smoking?  No  Yes \_\_\_\_\_ packs per day, for \_\_\_\_\_ years

Quit smoking?  This year  + 1 year  + 5 years  + 10 years

Previously smoked \_\_\_\_\_ packs per day \_\_\_\_\_ years

Drink alcohol?  Yes  No

Daily  1-2x/week  1-2x month  Rarely

For FKOC Internal Use _____
Date of Data Entry _____
Initials _____

PATIENT \_\_\_\_\_ date \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ date \_\_\_\_\_ Knae

PATIENT NAME \_\_\_\_\_

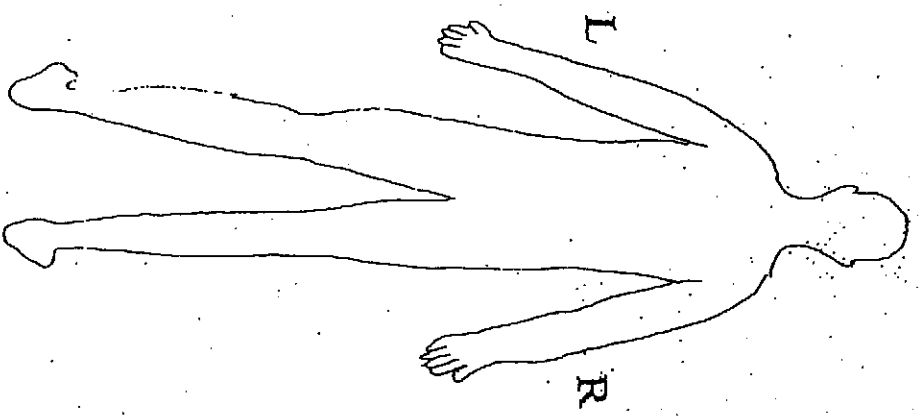
DATE \_\_\_\_\_

**PAIN DRAWING**

Mark the area on your body where you feel the described sensations. Use the appropriate symbols.  
Mark the areas where the sensations travel, if any. Please include all affected areas. Just to complete the picture,  
please draw your face.

ACHE	NUMBNESS	PINS & NEEDLES	BURNING	STABBING
>>>>	====	00000	x x x x	////
>>>>	====	00000	x x x x	////
>>>>	====	00000	x x x x	////

**Back**



**Front**

