Spine Surgery Croatia
Minimally-invasive spine surgery

SPINE PATIENT HISTORY FORM

Name ________________________________ **Age** ____________

Occupation ________________________________ **Date** ____________

1. What date (roughly, at least) did your present pain start? ____________________

2. Mechanism of pain onset:

- ☐ Suddenly
- ☐ Gradually
- ☐ Lifting
- ☐ Twisting
- ☐ Fall
- ☐ Bending
- ☐ Pulling
- ☐ Injured at work
- ☐ Auto accident
- ☐ Hit in back
- ☐ Sports
- ☐ No apparent cause

3. What activities make the pain worse?

- ☐ During exercise
- ☐ After exercise
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Bending forward
- ☐ Bending backward
- ☐ Coughing
- ☐ Sneezing

4. What reduces your pain?

- ☐ Lying down
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Manipulation
- ☐ Physical therapy
- ☐ Pain pills
- ☐ Muscle relaxants
- ☐ Aspirin
- ☐ Other ____________________
- ☐ Nothing

5. How long have you had any back pain? __________ **years** __________ **months** __________ **weeks**

How long have you had any leg pain? __________ **years** __________ **months** __________ **weeks**

6. Have you had any diagnostic studies other than x-rays? ☐ **yes** ☐ **no**

Have you had a CAT scan? ☐ yes ☐ no Date ____________

Have you had the myelogram? ☐ yes ☐ no Date ____________

Have you had an EMG? ☐ yes ☐ no Date ____________

Have you had an MRI scan? ☐ yes ☐ no Date ____________

7. Have you been in the hospital for your back problem? ☐ **yes** ☐ **no**

Number of times ____________________ Dates ____________________

8. Have you had neck or back surgery? ☐ **yes** ☐ **no**

Number of times ____________________ Dates ____________________

9. Have you been in the hospital with other medical problems? ☐ **yes** ☐ **no**

Number of times ______________ Describe ____

10. Please list current medications ____

____

____

____

11. Do you take antacids? ☐ **yes** ☐ **no**

12. General medical problems:

☐ Stomach problems, ulcer, etc.	☐ Cancer
☐ Diabetes	☐ Heart
☐ Arthritis	☐ Epilepsy
☐ Gout	☐ Other ______________________
☐ Sexual difficulties	☐ Loss of weight
☐ Bowel or Bladder	

13. Allergies? ☐ **yes** ☐ **no** Please list ____

____

14. Do you smoke? ☐ **yes** ☐ **no** **How much?** ______________________________

15. Do you drink alcoholic beverages? ☐ **yes** ☐ **no** **How much?** ______________________

16. What other types of doctors have you seen for this condition? ______________________

____

17. Do you want a report sent to your attorney? ☐ **yes** ☐ **no** ☐ **I have no attorney.**

18. Do you have any additional information which would be helpful to understand your problem?

____

____

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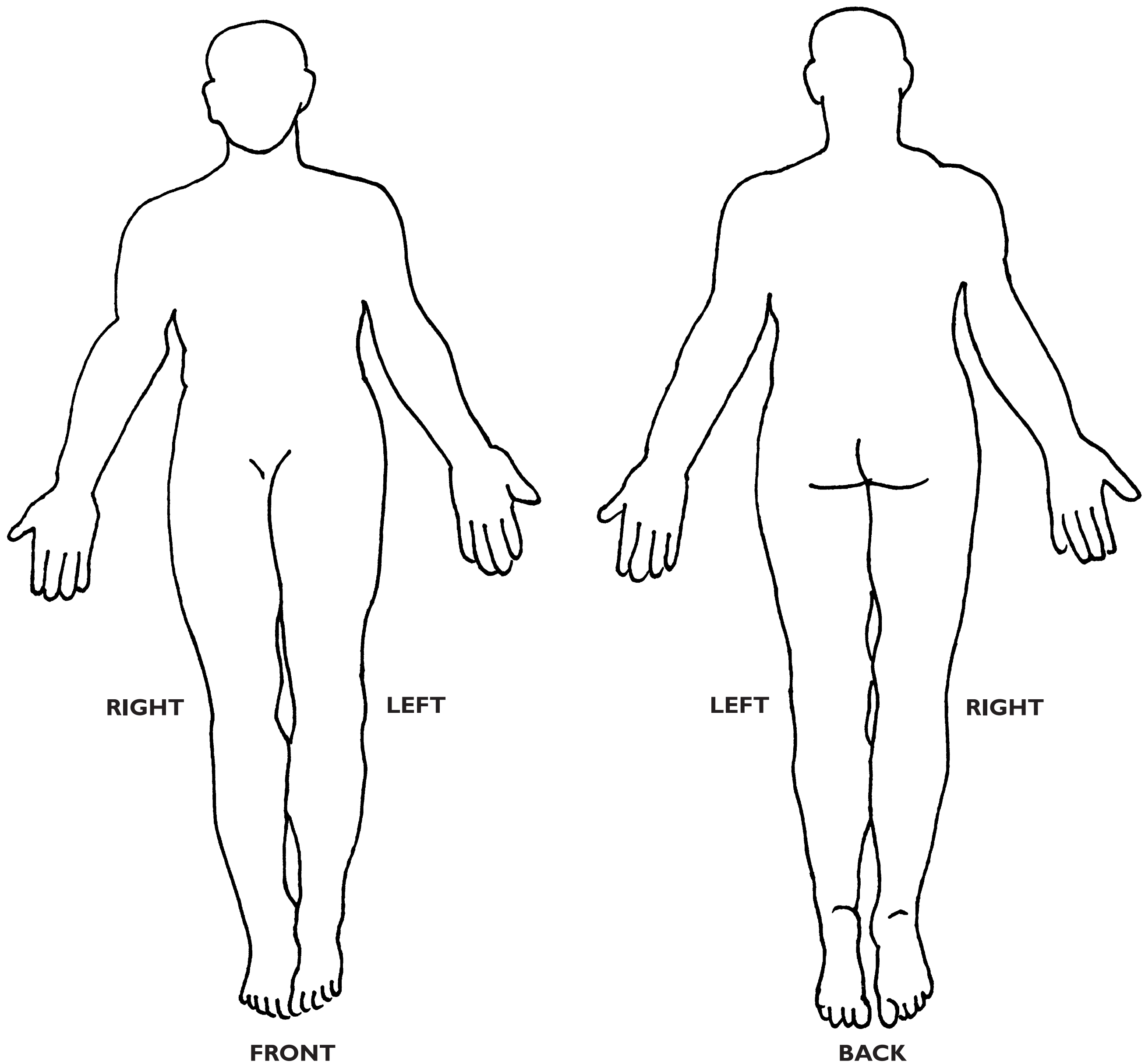
19. If you were referred by a previous patient, would you be willing to share their name with us so we can acknowledge them? Patient's name: ______________________________

Where is your pain now?

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas. Just to complete the picture, please draw in your face.

^^^^ ^^^^ **Ache**	oooo oooo **Numbness**	==== ==== **Pins & Needles**	xxxx xxxx **Burning**	//// //// **Stabbing**



Please mark on the line:

How bad is your back pain now? No pain ——— Worst possible

How bad is your leg pain now? No pain ——— Worst possible