ROCK CREEK NEUROSURGERY

15 South 1000 East, Suite 225
Payson, Utah 84651
CALL (801) 609-9310
Fax (801) 465-0901

www.RockCreekNeurosurgery.com

Name: _____ DOB: _____

1 Past Medical History

Check All That Apply

- ○ Anemia
- ○ Aneurysm
- ○ Asthma
- ○ Bipolar
- ○ Bleeding Disorder
- ○ Blood Clot
- ○ Brain Tumor
- ○ Bronchitis
- ○ Cancer
- ○ Crohn's Disease/Ulcerative Colitis
- ○ Depression
- ○ Diabetes
- ○ Emphysema/COPD
- ○ Epilepsy
- ○ Fibromyalgia
- ○ Gout
- ○ Heart Attack
- ○ Heart Failure
- ○ Hepatitis
- ○ HIV/AIDS
- ○ Hypertension
- ○ Irregular Heart Beat
- ○ Kidney Failure
- ○ Lung Disease
- ○ Mental Illness
- ○ MRSA
- ○ Osteoarthritis
- ○ Seizures
- ○ Stomach Ulcers
- ○ Stroke
- ○ Tuberculosis
- ○ None

2 Past Surgical History

Have you ever had surgery? No ○ Yes ○ Please list any surgeries and/or hospitalizations and year: _____

_____

_____

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Medication History

Please list your current medications and bring list to your appointment
(Over the counter, Prescriptions, Herbal, etc)

Name of Medication	Dose/ Strength	Frequency

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Allergies

Are you allergic to anything? No ○ Yes ○ Please list any allergies: _____

_____

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Family History

Check All That Apply

Aneurysm ○ Back/Neck Problems ○ Bleeding Disorder ○ Brain Tumor ○
Cancer ○ Depression ○ Epilepsy ○ Heart Disease ○
Muscle Disease ○ Parkinson's Disease ○ Stroke ○

Other ○ _____

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Social History

Marital Status: Married ○ Single ○ Widowed ○ Divorced ○

Highest level of education: _____

I live: Alone ○ With: _____

Tobacco Use:

Never ○ Cigar ○ Chew ○ Pipe ○
Cigarettes ○ (_____ packs/day for _____ years). Quit- When_____

Alcohol: Never ○ Rarely ○ Social ○ Frequently ○ Recovering Alcoholic ○

Drug Use: Never ○ Currently ○ In the past ○ Which ones? _____

Current Work Status: Full time ○ Part time ○ Unemployed ○ Retired ○ Disabled ○

If disabled, since what time? _____

Occupation (if retired list prior occupation) _____

Does work require long Standing ○ Sitting ○ Walking ○ Lifting ○

Does it include heavy labor? _____ How much are you required to lift? _____

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Review Of Systems

Check all that apply

Constitutional
- ○ Fatigue
- ○ Fever
- ○ Loss of Appetite
- ○ Weight gain in last 12 mos
- ○ Weight loss in last 12 mos
- ○ None

Eyes
- ○ Blurred Vision
- ○ Double Vision
- ○ Light Sensitivity
- ○ Loss of Vision
- ○ None

HENT
- ○ Bleeding Gums
- ○ Loss of Hearing
- ○ Loss of Taste/Smell
- ○ Nose Bleeds
- ○ Ringing (Tinnitus)
- ○ None

Cardiovascular
- ○ Chest Pains
- ○ High Blood Pressure
- ○ Low Blood Pressure
- ○ Heart racing
- ○ None

Respiratory
- ○ Shortness of Breath
- ○ Wheezing
- ○ None

Gastrointestinal
- ○ Nausea
- ○ Vomiting
- ○ Diarrhea
- ○ Bowel Accidents
- ○ None

Genitourinary
- ○ Incontinence
- ○ Urinary Hesitance
- ○ Urinary Frequency
- ○ Sexual Difficulty
- ○ None

Integument
- ○ Skin Sores
- ○ Abscess
- ○ None

Musculoskeletal
- ○ Fractures
- ○ Gait Problems/Coordination
- ○ None

Neurologic
- ○ Headaches
- ○ Seizures/Epilepsy
- ○ Loss of Consciousness
- ○ Dizziness / Vertigo
- ○ Paralysis/ Weakness
- ○ Numbness
- ○ Speech Difficulties
- ○ Confusion
- ○ Falls
- ○ Tingling
- ○ Head Injury
- ○ None

Endocrine
- ○ Excess Thirst
- ○ Glandular or Hormone Problems
- ○ None

Psychiatric
- ○ Memory Loss or Confusion
- ○ Anxiety
- ○ None

Heme-Lymph
- ○ Bleeding Tendencies
- ○ Blood Clots
- ○ None

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Symptoms/Previous Treatment

Where are your symptoms primarily located?

Neck ○ Lower back ○ Other ○ _____

When did these symptoms start? _____

How long? _____ Constant ○ Intermittent ○

Do you have pain radiating into the extremities?

Right arm ○ Left arm ○ Right Leg ○ Left Leg ○ Buttock Only ○

Please mark those that apply:

Numbness ○ Sharp pain ○ Burning ○ Dull Throb ○ Constant ○ Intermittent ○

What makes your pain worse? Sitting ○ Standing ○ Lying down ○ Walking ○

What makes your pain better? Sitting ○ Standing ○ Lying down ○ Lifting ○ Walking ○

Medications ○ Rest ○ Ice ○ Heat ○

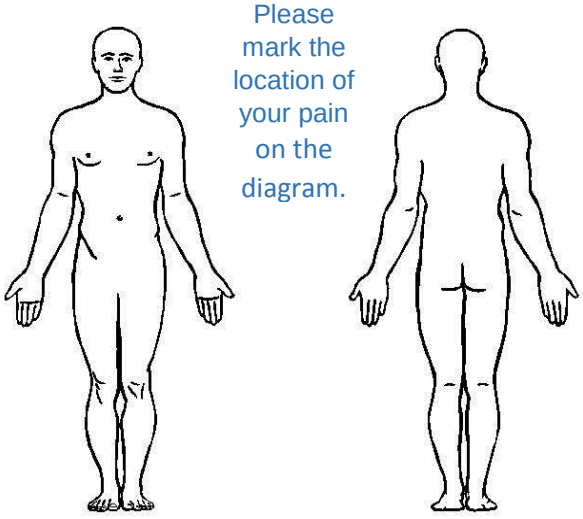
Have you ever lost control of your bowel or bladder? Yes ○ No ○

If yes, please describe: _____

Is the pain a result of: Auto accident ○ Fall ○ Is this a worker's comp injury? Yes ○ No ○

Is there a lawsuit pending involving the injury? Yes ○ No ○

Please mark the location of your pain on the diagram.



Physical Therapy: Yes ○ No ○

How many sessions? _____When _____

What Facility? _____

Epidural or other types of injections? Yes ○ No ○

How many _____ When _____

What Facility? _____

EMG testing: No ○ Yes ○ Where performed _____

Prior Surgery on Cervical or Lumbar Spine? No ○ Yes ○

What procedure? _____ Date of procedure? _____

Who performed? _____

Patient Signature _____

Pain Scale

This questionnaire is designed to enable us to understand how much your pain has affected your ability to manage everyday activities. Please circle the 1 choice which closely describes your problem right now.

Section 1- Pain Intensity

A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

Section 2- Personal Care

A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increase the pain, but I manage not to change my way of doing it.
D. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain, I am unable to do any washing and dressing without help.

Section 3- Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it causes extra pain.
C. Pain prevents me from lifting heavy off the floor, but I can manage if they are easily located, e.g. on a table.
D. Pain prevents me from lifting heavy weights, but I can lift light to medium weights if they are easily located.
E. I can only lift very light weights at the most.
F. I cannot lift or carry anything at all.

Section 4- Walking

A. I have no pain walking.
B. I have some pain with walking but does not change.
C. I cannot walk more than 1 mile without increasing pain.
D. I cannot walk more than ½ mile without increasing pain.
E. I cannot walk more than ¼ mile without increasing pain.
F. I cannot walk without increasing pain.

Section 5- Sitting

A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than an hour.
D. Pain prevents me from sitting more than ½ hour.
E. Pain prevents me from sitting more than 10 minutes.
F. Pain prevents me from sitting at all.

Section 6- Standing

A. I can stand as long as I want without pain.
B. I have some pain with standing that does not increase with time.
C. Pain prevents me from standing for greater than 1 hour.
D. Pain prevents me from standing for greater than ½ hour.
E. Pain prevents me from standing more than 10 minutes.
F. I avoid standing because it increases pain right away.

Section 7- Sleeping

A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping.
C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

Section 8- Social life

A. My social life is normal and gives me no pain.
B. My social life is normal but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from my more energetic interests e.g. dancing
D. Pain has restricted my social life, and I do not go out often.
E. Pain has restricted my social life to my home.
F. I have no social life because of pain.

Section 9- Traveling

A. I have no pain with traveling.
B. I get some pain with traveling, but none of usual forms of traveling make it worse.
C. I get extra pain with traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain with traveling, which compels me to seek alternative forms of travel.
E. Pain restricts me to short necessary journeys under ½ hour.
F. Pain restricts all forms of travel.

Section 10- Changing degree of pain

A. My pain rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is worsening every day.