SURGICAL SPINE ASSOCIATES

Eugene A. Bonaroti MD Board Certified Neurosurgeon

www.surgical-spine-associates.com

Telephone: 412.275.0227 Fax: 412.291.2111

Office Locations:

Greensburg
One Aesthetic Way
Greensburg, PA 15601

Scheduling Soon!
Cranberry
One Adams Place
310 Seven Fields Blvd
Seven Fields, PA 16046

Procedure Locations:

Greensburg
One Aesthetic Way
Greensburg, PA 15601

Fox Chapel
107 Gamma Drive
Pittsburgh, PA 15238

South Hills
100 Trich Drive
Washington, PA 15301

New Patient Packet

Welcome to Surgical Spine Associates. We are pleased that you have entrusted us with your health care needs. Please carefully review the packet and answer **all** questions to the best of your knowledge. We appreciate your compliance with completing all forms **prior** to your office visit so that we can develop the best plan of care for you.

How to Best Prepare for Your Appointment:

1. Please arrive **15 minutes** prior to your scheduled appointment time.
2. You must present with a photo I.D. (driver's license, passport, government issued I.D. card) and medical insurance card in order to be seen.
3. Complete all forms included in your New Patient packet **before** your appointment.
4. Bring all imaging studies (MRI, CT scan, X-rays, Nerve Studies EMG/NCV) and radiology reports that pertain to your problem. Please be aware that Surgical Spine Associates is a private practice and cannot access your records from outside facilities without a record request.
5. Wear comfortable clothing. You will be asked to remove your shoes for a Neurologic examination.

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know you have carefully reviewed every area of this form. It will be entered into our electronic health record to ensure the best possible care for you.

Patient's Last Name _____ **First** _____ **MI** _____

Sex ☐ Male ☐ Female **Date of Birth:** _____
Name of Primary Care Physician: _____ **Phone # of PCP:** _____
Name of Referring Physician: _____ **Phone # of referring:** _____
Name of Emergency Contact: _____ **Phone #** _____
Pharmacy Preference (include location): _____ **Phone #** _____

REASON FOR TODAY'S VISIT: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATIONS? ____Yes ____ No. If yes, please list below:

Name of Medication	Type of Reaction*

Latex Allergy: ☐Yes ☐No IV Contrast Allergy: ☐Yes ☐No

SURGERIES, HOSPITALIZATIONS AND MEDICAL CONDITIONS. If yes, please list:
SURGERIES: _____
_____
_____
_____
HOSPITALIZATIONS: _____
_____
MEDICAL CONDITIONS: _____
_____

RECENT DIAGNOSTIC TESTS, MRI'S, X-RAY'S, EMG'S (Please indicate when/where these were performed):
_____
_____
_____

Have you ever had any problems with **anesthesia** (being numbed or put to sleep)? ☐Yes ☐No
Have you ever been hospitalized for **non-surgical** reasons? ☐Yes ☐No
If yes, list reasons for hospitalizations _____
_____

Surgical Spine Associates

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Phone: (412) 275-0227 Fax: (412) 291-2111

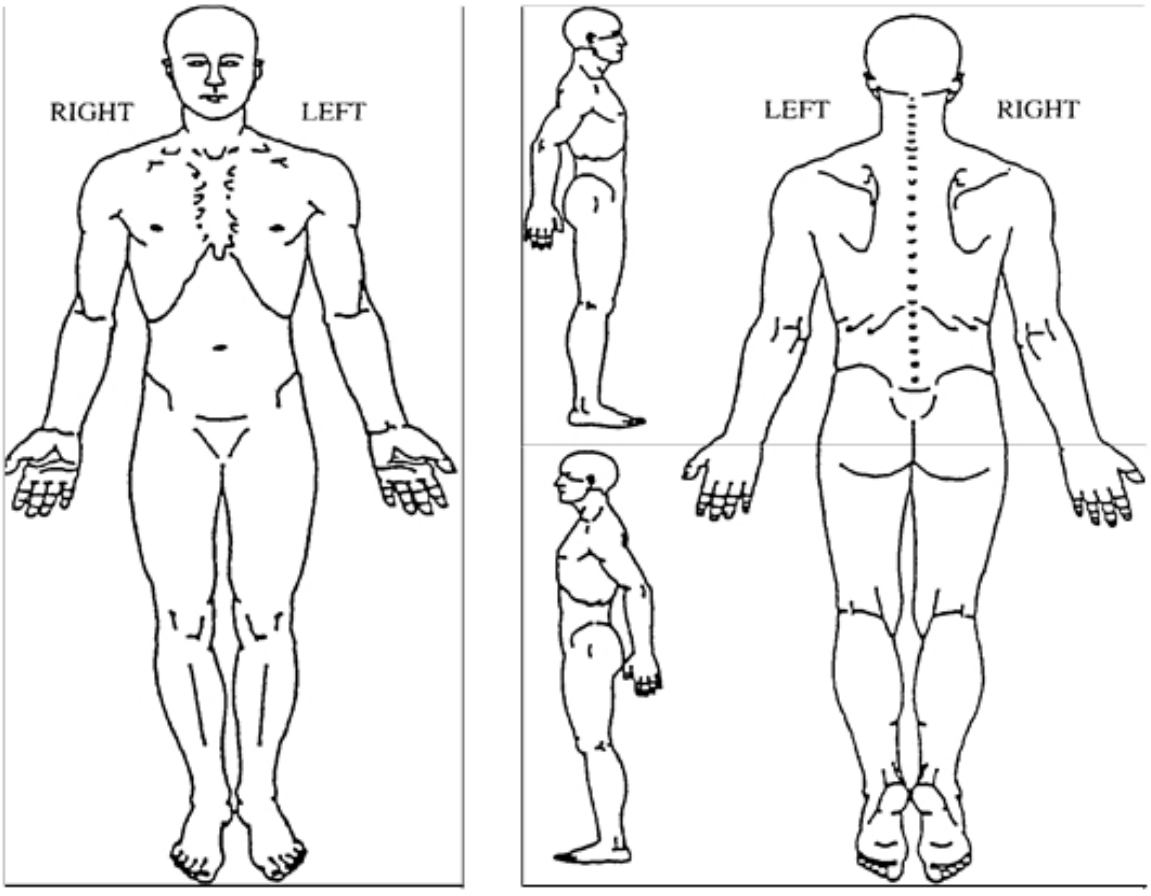
1. Name: _____
   First Middle Initial Last

2. Height _____Weight_____ 3. Date of Birth: _____

Characteristics of Pain

1. What is the main complaint for which you are seeking treatment at Surgical Spine Associates?

2. On the diagram, shade in the areas where you feel pain. Put an "X" on the area that hurts the most.



3. How long have you had the pain problem you are currently experiencing (in months and years)?

4. What caused your current pain?

5. Describe the characteristics of your pain (circle each that describes your pain).

Piercing	Throbbing	Numbing
Stabbing	Cramping	Itching
Shooting	Aching	Tingling
Burning	Stinging	None
Grinding	Squeezing	

6. Please circle all associated symptoms of your pain:

Numbness	Incontinence of bowel	Cool, pale skin
Weakness	Tenderness of affected area	Swelling
Urinary Incontinence	Pain with only a light touch	Redness

Other:_____

Rate your pain by placing an "X" on the line to best describe your pain at its WORST in the past month.

No Pain _____ Pain as bad as it could be

7. Rate your pain by placing an "X" on the line to best describe your pain at its LEAST in the past month.

No Pain _____ Pain as bad as it could be

8. How often do you have pain?
   a. ☐ Constantly (80-100% of the time)
   b. ☐ Nearly constantly (50-80% of the time)
   c. ☐ Intermittently (25-50% of the time)
   d. ☐ Occasionally (less then 25% of the time)

9. What kinds of things make your pain feel better? (example: sitting, sleeping, etc.)

10. What kinds of things make your pain feel worse? (example: standing, lifting, etc.)

SECTION MUST BE COMPLETED.

1. Please indicate which treatments you have tried in the past. Choose the corresponding number indicating the relieving effect on your pain**: PLEASE INCLUDE THE DATE AND DURATION.**

1 – Worsened Pain 2 – No Relief 3 – Partial Relief 4 – Complete Relief

	DATE		DATE		DATE
___Acupuncture	_____	___Hospital Bed Rest	_____	___SI joint injection	_____
___Biofeedback	_____	___Hypnosis	_____	___Spinal Cord Stimulator	_____
___Chiropractor	_____	___Nerve Block	_____	___TENS (Elect Stim)	_____
___Epidural Steroid Inj.	_____	___Physical Therapy	_____	___Traction	_____
___Exercise	_____	___Psychotherapy	_____	___Facet Rhizotomy	_____
___Hot/Cold Tmts	_____	___Surgery	_____	___Pain Pump	_____

If you have had prior neck or back surgery, please indicate the surgery performed:

_____

2. Have any other health care professionals and/or specialists been involved in the evaluation and treatment of your current pain? **If so, please state their name, specialty, and/or their practice name if known.**

Past Medical History

1. Aside from your pain problem, how is your general health? (please check one item)

☐Excellent ☐Minor Health Problems ☐Major Health Problems

2. Have you had any of the following health problems? (please circle all that apply)

Headaches/Migraines	Obstructive Sleep Apnea	Fractures
Neurologic Disorder	Asthma or Wheezing	Blood Disorder
Seizures or Epilepsy	Chronic Cough	Anemia
Transient Ischemic Attack/Stroke	Stomach Ulcer	Blood Clots: Pulmonary/DVT
Chest Pain	History of Polyps	Cancer
High Blood Pressure	Liver Disease/Hepatitis/Cirrhosis	Depression
Heart Attack	Diabetes or High Blood Sugar	Mania
Heart Rhythm Disorder	Thyroid Disease	Suicidal Tendency
Valvular Heart Disease	Kidney Disease	Other:
Pacemaker/AICD	Muscle Disease	
Lung Disease	Arthritis	

Review of Symptoms

Please **circle the symptoms** listed below that you have experienced in the past few months. If you are not having any of these difficulties, please check "No Problems."

Const. (Health in General) ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, prior diagnosis of cancer.
Other:_____

Ears, Nose, Mouth & Throat ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, dental problems, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: _____

C-V (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

Resp. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____

GI (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

GU (Kidney & Bladder) ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

MS (Muscles, Bones, Joints) ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

Integumentary (Skin, Hair & Breast) ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

Psychiatric (Mood & Thinking) ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrinologic (Glands) ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

Family Medical History

1. Please list any medical conditions that are present in your family: _____

2. Is there any family history of anesthesia or surgical problems? ☐Yes ☐No

If yes, please describe: _____

Social History

1. Current or previous occupation:_____
2. Present employment status:

   ☐Full Time ☐Unemployed ☐Leave of Absence ☐Student

   ☐Part Time ☐Retired ☐Homemaker
3. Substance intake per day: (Please indicate how often you use or consume the following)
   a. Caffeine (coffee, tea, cola, etc.)_____
   b. Nicotine (Cigarettes, cigar, pipe, smokeless tobacco, etc)_____
4. Your present use of alcoholic beverages is (choose one):

   ☐None ☐Occasionally (less than 1 drink per week) ☐Daily

   ☐Rarely(less than one drink per month) ☐Regularly (drink 2-3 times per week)

   Have you ever made a conscious effort to decrease your drinking? ☐Yes ☐No

   Has anyone ever irritated you by suggesting that you decrease your drinking? ☐Yes ☐No

   Have you ever felt bad about your drinking? ☐Yes ☐No
5. Have you ever used any of the following drugs? Choose all that apply.

   PLEASE INDICATE WHEN LAST USED in the space provided.

   ☐Marijuana _____ ☐Cocaine _____ ☐Other Street Drugs _____

   ☐Amphetamines _____ ☐Heroin _____ ☐ None of these
6. Marital Status (choose one):

   ☐Single ☐Divorced ☐Widowed

   ☐Married ☐Separated ☐Remarried
7. Number of children:_____
8. Present living situation:

   ☐Alone ☐With Children ☐With friend

   ☐With Spouse ☐With Parents ☐With other family members
9. Education (check the highest grade/degree completed):

   ☐Less than 8th grade ☐Some high school ☐Some college ☐Advanced degree

   ☐Completed 8th grade ☐High school graduate ☐College graduate

Signature of Patient: _____ **Date Completed:** _____

If form has been completed by someone *<u>other</u>* than the patient, please print and sign name below:

Name: _____

Signature:_____

Relationship to Patient:_____

Signature of Reviewer: _____ M.D. / NP-C / PA-C