Remi M. Ajiboye, M.D., M.P.H.
Minimally Invasive Spine Surgery
Sports and Spine Orthopaedics

Clinical Patient Information and Medical History – SPINE PATIENTS

(Please type or print legibly)

Name: _____ **Date**:_____

Age:_____ **Date of birth**:_____ **Sex**: □ Male □ Female **Occupation**:_____

BP_____**P**_____**RR**_____**Wt** _____ **HT**_____ **Hand dominance:** □ Right □ Left

Referring physician:_____ **Primary care physician (if any):**_____

Chief complaint: (what are you here for today?) _____

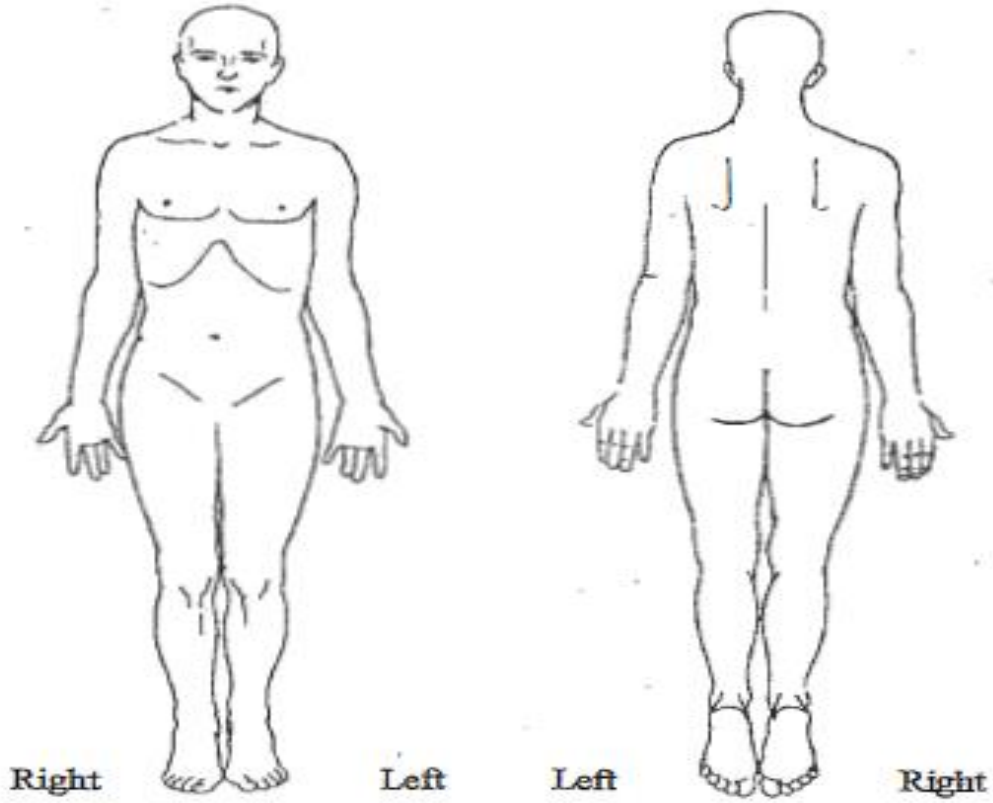
What is the most important thing that you want accomplished today:_____

Do you have any of the following symptoms: □ Balance problems □ Difficulty holding onto objects □ Weakness
□ Bladder hesitancy □ Night pain □ Weight loss/gain

Pain Drawing

This pain drawing will help us understand the pain you have been experiencing.
Please diagram your pain using the following symbols:

Numbness: ——— **Pins & Needles:** oooooooooo **Stabbing:** //////////
Burning: xxxxxxxxx **Other:** ^^^^^^^ ***(please describe)***



Symptoms onset date:_____ **Pain intolerable since**:_____

Accident related: □Yes □No □Motor vehicle □Industrial

Check one if applicable:
□ARM pain greater than NECK pain □NECK pain greater than ARM pain
□LEG pain greater than BACK pain □BACK pain greater than LEG pain

What position or activity makes your pain worse:_____

What position or activity makes your pain better:_____

Prior treatment:

□Physical therapy	Relief? □Yes	□No	Duration of treatment: _____
□Chiropractic therapy	Relief? □Yes	□No	Duration of treatment: _____
□Acupuncture	Relief? □Yes	□No	Duration of treatment: _____
□Massage therapy	Relief? □Yes	□No	Duration of treatment: _____
□Bracing	Relief? □Yes	□No	Duration of treatment: _____
□Pain medications	Relief? □Yes	□No	Duration of treatment: _____
□Injection	Relief? □Yes	□No	Duration of treatment: _____
□Other (please describe): _____			

Past Medical history: (please check previous or current conditions)

□ None	□ Anemia	□ COPD/lung disease	□ High blood pressure	□ Prostate
	□ Arthritis	□ Depression	□ High cholesterol	□ Stomach ulcers/reflux
	□ Asthma	□ Diabetes	□ HIV/AIDS	□ Seizures
	□ Blood clots/DVT	□ Heart disease	□ Liver disease	□ Thyroid disease
	□ Cancer	□ Hepatitis	□ Osteoporosis	□ Vascular disease

□ Other (please list) _____

Previous surgeries: (list type of surgery, year, where, by whom, etc)

_____
_____

Current medications: (list name, dosage, frequency of use, etc)

_____
_____

Allergies (list allergy and reaction) _____

Review of systems: (Check any positives)

General	□ Fatigue	□ Weight loss /gain	□ Fever /chills
Heart	□ Shortness of breath	□ Chest pain	□ Palpitations
Lungs	□ Productive cough	□ Wheezing	□ Coughing up blood
GI	□ Heartburn	□ Abdominal pain	□ Nausea/vomiting
Urinary/reproductive	□ Blood in urine	□ Incontinence	□ Sexual dysfunction
Skin	□ Skin lesions	□ Psoriasis	□ Chronic rash
Neurological	□ Seizures	□ Migraines	□ History of stroke
Musculoskeletal	□ Joint pain	□ Joint swelling	□ Muscle pain
Psychiatric	□ Depression	□ Anxiety	□ Mood swings
Hematologic	□ Easy bruising	□ Easy bleeding	

Family and social history:

Marital status: □ Single □ Married □ Divorced □ Widowed Children (if any, list ages):_____

Medical problems common in your parents or siblings (please describe): _____

Who do you live with:_____

Do you smoke? □ Yes □ No Packs/day? _____ How many years?_____ Date quit?_____

Do you drink alcohol? □ No □ Rare □ Social □ Daily Do you use any other drugs (please describe): _____

PHYSICAN USE ONLY

	D	B	TRI	WE	WF	INT	G	C5	C6	C7	C8	T1

Cervical R
L

	HF	Q	TA	EHL	GS	L2	L3	L4	L5	S1

Lumbar R
L

Exacerbating					B	BR	Hoffman	Spurling	PAT	ACH	SLR
Ameliorating				R							
Walking tolerance				L							

Other:_____