Patient Info Sheets for Dr. Lowen, Scott Howell, Caroline Rangel Patients, CERVICAL

PATIENT'S NAME: _____ DATE: _____ D.O.B.:_____

PLEASE CIRCLE AND/OR FILL IN THE ANSWERS TO THE FOLLOWING QUESTIONS

Who referred you to our office?_____ Who is your family physician? _____

Other physicians who should receive correspondence about today's visit?

What is your age? What is your sex? Male Female

What do you do for a living?

Main Complaint

What is your main complaint?

Neck Pain Which side? Right Left Center
Arm Pain Which Arm? Right Left Both
Both arms Which arm is worse? Right or Left

If your **Arm pain is worse** than your neck pain, how much percentage % worse?
90 vs. 10 80 vs. 20 70 vs. 30 60 vs. 40 50 vs. 50

If your **Neck pain is worse** than your arm pain, how much percentage % worse?
90 vs. 10 80 vs. 20 70 vs. 30 60 vs. 40 50 vs. 50

Have you had **previous Cervical Spinal Surgery**? Yes No

Surgery Type: Laminoplasty Diskectomy Fusion Corpectomy
When? (mo/yr) Where was surgery done?
Surgeon's Name:
Why was it done?: Due to neck pain? Due to arm pain? Due to both neck and arm pain?
If arm pain, which arm? Right Left
Did the surgery help? For how long?

Duration of Symptoms

How long have you had the neck pain?____ years ____months ____weeks ____days
How long have you had the arm pain? ____ years ____months ____weeks ____days

Are the symptoms episodic? Yes No How many episodes per year? _____ episodes/year
The current episode has been present for ____ years ____months ____weeks

Since the onset of the current symptoms, you feel: Better Worse Same
If better, what percentage % better: _____ % better
If worse, how much worse? _____

Does the Arm Pain travel down your arm? Yes No
If yes, **circle** the location(s) where the pain travels to:
Trapezius Shoulder Upper arm Biceps Triceps Elbow Forearm Wrist Hand Fingers

Injury

Were you injured? Yes No What happened?

Motor Vehicle Crash Yes or No

Date of Accident: _____

Did you wear a seat belt? Yes No

You were the: Driver or Passenger. (Front Seat or Back Seat)

Your vehicle was a : _____make _____model

Collided with a : _____make _____model

Collision: Rear End Collision vs Front End Collison vs Side Impact Collision

Your estimated rate of speed High speed ____mph Low speed ____mph

Other vehicle's estimated rate of speed High speed ____mph Low speed ____mph

Damage to you car: Car was totaled. Vs. Car had $ _____ worth of damage.

Did you have pain prior to this accident? Yes No

Description of Pain (circle):

Arm Pain: Sharp Dull Aching Burning Stabbing Electrical

The Arm Pain: **Comes and goes** or **is constant?**

Is the arm pain excruciating? Yes No Is the arm pain agonizing? Yes No

Arm pain wakes you up at night? Yes No

Is the arm pain: Livable or Not Livable?

Arm symptoms worsen with: Athletic Activity Driving Walking Standing Sitting Lying Down

Arm symptoms are improved with: Lying down Sitting Walking

Pins and Needles Sensation down arm? Yes No

Numbness and Tingling down the arm? Yes No

Arm pain is worse when you cough or sneeze? Yes No

Arm pain improves with placing your arm on top of your head? Yes No

Arm bothers you when reaching overhead? (for example, kitchen cabinet) Yes No

Arm bothers you when reaching behind? Yes No

Do you have difficulty with your handwriting? Yes No

Difficulty picking up small coins off a table? Yes No

Trouble buttoning buttons? Yes No

Do your hands feel clumsy? Yes No

Do you have problems with your balance? Yes No

Any recent falls because of poor balance? Yes No

Neck Pain: Sharp Dull Aching Burning Stabbing

The Neck Pain: **Comes and goes** or **is constant?**

Is the neck pain excruciating? Yes No Is the neck pain agonizing? Yes No

Neck pain wakes you at night? Yes No

Is the neck pain: Livable or Not Livable?

Neck symptoms worsen with: Athletic Activity Driving Walking Standing Sitting Lying Down

Neck symptoms worsen with: Turning head Left or Turning head Right

Neck symptoms are improved with: Lying down Sitting Walking

Exercise:

Exercise Routine: _____ days per week.

Type of exercise: Treadmill Stationary bike Elliptical machine Swimming Weightlifting

Other types of exercise:

Sports: Tennis Golf Other_____ _____ times per week

Walking: How far can you walk comfortably?
Unlimited 1 – 2 blocks Less than ½ block Not able to walk
How far can you walk before you must stop and sit? _____ (distance)
You can get up and continue walking after _____ minutes of rest.
Do you use an assistive device? Cane Walker Wheelchair
How long have you been using this? _____

Arm Weakness? Yes No Which arm? Right Left

Bladder Problems:
Incontinent of urine? Yes No Date it started:_____0

Treatment for this problem thus far:

What **Medications** have you taken for the **Pain**?
Anti-Inflammatories:
Celebrex, Mobic, Motrin, Ibuprofen, Naprosyn, Relafen, Daypro, Lodine, Steroid Dosepak, Aleve, Advil.
Narcotic Medications:
Percocet, Vicodin, oxycodone, Codeine, OxyContin, Oxy-IR, Lortab, Duragesic Patch
Other types:
Neurontin, Lyrica, Ultram, Ultracet, Valium, Soma, Skelaxin, Flexeril, Topamax, Cymbalta, Elavil, Tylenol.
Pain Patches:
Duragesic patch, Flector patch, Lidoderm patch.

What Medications are you taking **currently** for the **pain**? **What dose and how often**?
1. 4.
2. 5.
3. 6.

Have you ever had **cervical facet blocks?** Yes No
When? _____ How many? _____ By whom? _____
Did the injections help? Yes No

Have you ever had **cervical epidural steroid injections?** Yes No
When? _____ How many? _____ By whom? _____
Did the injections help? Yes No

Have you had any **physical therapy?** Yes No
How many times per week? _____ How many weeks? _____
Did the physical therapy help? Yes No
When was your last session of physical therapy? _____ (Date)

Have you used a **neck brace?** Yes No Did it help? Yes No

What **other treatments** have you had? Chiropractic. Massage. TENS unit. Acupuncture?
Other? _____

PAST MEDICAL HISTORY: Please circle all that you have.

Diabetes	Parkinson's disease	Fibromyalgia	Coronary artery disease
Stroke	Stomach ulcers	Kidney disease	Heart Attack _____when?
Osteoporosis	Hiatal hernia	Panic/anxiety attacks	Heart disease
Osteopenia	GERD	Depression	Atrial fibrillation
Osteoarthritis	Gastritis	Psoriasis	Cancer _____ type?
Hypertension	Colon problems	Rheumatoid arthritis	High cholesterol
Liver disease	Irritable bowel	Prostate problems	Hepatitis _____ type?
Lung disease	TMJ syndrome	Insomnia	HIV/AIDS
Bronchitis	Migraine headaches	Platelet abnormalities	Thyroid problems
Asthma	Bone marrow cancer	Bone marrow abnormalities	

Others:

PAST SURGICAL HISTORY:

Pacemaker	Defibrillator implant	Coronary artery bypass graft
Stents-cardiac	Knee arthroscopy	Colon cancer surgery
Stents-aortic	Hip replacement	Breast cancer surgery
Stents-legs	Knee replacement	Lung cancer surgery
Kidney surgery	Shoulder surgery	Tonsillectomy
Hysterectomy	Gallbladder	Appendectomy
Carotid surgery	Spine surgery _____	

Other surgeries:

SOCIAL HISTORY:

Do you smoke? No Yes _____ How many packs per day?
Do you drink alcohol ? No Yes _____How much per day?
Married Single Live alone? In an Assisted Living Facility? In your own home?

MEDICATIONS: Please list.

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Others:

Are you currently taking any of the following anticoagulants or anti-platelet medications: (Circle)

Coumadin? Plavix? Aspirin? Baby aspirin? Pradaxa? Xarelto? Aggrenox? Effient? Eliquis? Persantine? ReoPro? Lovenox?

ALLERGIES to medications: Penicillin Sulfa Codeine Aspirin.
Others: Please list any other antibiotics, narcotics, etc. that you are allergic to.

1.	3.
2.	4.

HEIGHT: _____ **WEIGHT:** _____

REVIEW OF SYSTEMS:
Do you have any of the following?

Sinus problems? _____	Blurred Vision? _____	Decreased Hearing? _____
Sore Throat? _____	Abnormal Heart Beat? ____	Heart Attack? _____
High Cholesterol? _____	Thyroid Problems? _____	Fatigue? _____
Shortness of Breath? _____	Chest Pain? _____	Abdominal Pain? _____
Constipation? _____	Diarrhea? _____	Nausea? _____
Vomiting? _____	Unexplained Wt. Loss?____	Blood in Stool? ____
Incontinence of Stool? ____	Incontinence of Urine? ____	Problems w/ Urination? ____
Pain in Legs? _____	Swelling in Legs? _____	Poor Circulation in Legs? ____
Depression? _____	Anxiety? _____	

FAMILY HISTORY:
Do you have a positive family history for any of the following?
Scoliosis? _____ Osteoporosis? _____ Spinal stenosis? _____