

# SUNSHINE SPINE & PAIN, P.A.

**Patient name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Social history:**      **Right Handed ( )**      **Left Handed ( )**

Alcohol: ( ) None      ( ) Daily      ( ) Few per week      ( ) 1 per week      ( ) few per month      ( ) rare  
Drug Use: ( ) None      ( ) Other \_\_\_\_\_      Ever been in drug/Alcohol Treatment ( ) Yes      ( ) No  
Smoker ( ) yes ( ) # packs daily \_\_\_\_\_ how many years \_\_\_\_\_ when stopped \_\_\_\_\_

\*\*\*\*\*We strongly recommended smoking cessation

## **Family History:**

Mother ( ) Alive      ( ) Deceased... Age \_\_\_\_\_ Cause/medical conditions \_\_\_\_\_  
Father ( ) Alive      ( ) Deceased... Age \_\_\_\_\_ Cause/medical conditions \_\_\_\_\_  
Family Medical Problems ( ) Diabetes      ( ) Heart Disease      ( ) Cancer \_\_\_\_\_ ( ) Other \_\_\_\_\_

## **Review of Systems:**

Possibly Pregnant: ( ) Yes      ( ) No

( ) None      **General**      ( ) numbness/tingling      yes/ no      WHERE? \_\_\_\_\_      **OLD/NEW**

( ) new incontinence (urine / stool)      ( ) Coordination/ Off Balance

( ) None      **Constitutional**      ( ) fever      ( ) weight loss      ( ) tiredness

( ) None      **Eyes**      ( ) blurred vision      ( ) Haloes around lights      ( ) double vision

( ) None      **Ear Nose Throat** ( ) deafness      ( ) ringing      ( ) dizziness      ( ) vertigo

( ) None      **Heart**      ( ) chest pain      ( ) irregular heart beat      ( ) pounding in chest

( ) None      **Lungs**      ( ) shortness of breath      ( ) wheezing      ( ) cough

( ) None      **Abdomen**      ( ) diarrhea      ( ) constipation      ( ) black stools      ( ) heartburn      ( ) Stomach bleeding

( ) None      **Urinary**      ( ) burning      ( ) loss of urine      ( ) kidney disease

( ) None      **Menstrual**      ( ) regular      ( ) irregular      ( ) severe pain      ( ) post menopausal

( ) None      **Musculoskeletal** ( ) sprains      ( ) swelling      ( ) stiffness

( ) None      **Skin/Breast**      ( ) rash      ( ) sores      ( ) masses

( ) None      **Neurologic**      ( ) balance problems      ( ) memory problems      ( ) falls

( ) None      **Behavioral**      ( ) depression      ( ) anxiety      ( ) sleep disturbance

( ) None      **Endocrine**      ( ) sleep all time      ( ) hyperactive      ( ) too hot      ( ) too cold

( ) None      **Blood/lymphatic** ( ) easy bruising      ( ) bleeding problems      ( ) anemia

( ) None      **Immunologic**      ( ) itching      ( ) frequent colds/infections

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Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Height : \_\_\_\_\_ Weight: \_\_\_\_\_ #

Family Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

## Occupation:

**Do you have trouble getting numb at the dentist:** ( ) yes ( ) No

## Past Medical History: Check here if all are negative ( )

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> High blood pressure           | <input type="checkbox"/> <b>Hepatitis/liver disease</b> | <input type="checkbox"/> Phlebitis/ blood clots       |
| <input type="checkbox"/> <b>Heart disease</b>          | <input type="checkbox"/> <b>Kidney Problems/ Stones</b> | <input type="checkbox"/> <b>Stomach Ulcer disease</b> |
| <input type="checkbox"/> Heart attack                  | <input type="checkbox"/> Thyroid disease                | <input type="checkbox"/> <b>Bleeding disorder</b>     |
| <input type="checkbox"/> <b>Irregular heart rhythm</b> | <input type="checkbox"/> <b>Diabetes</b>                | <input type="checkbox"/> Asthma                       |
| <input type="checkbox"/> Stroke                        | <input type="checkbox"/> Osteoporosis                   | <input type="checkbox"/> Emphysema/ COPD              |
| <input type="checkbox"/> Seizures                      | <input type="checkbox"/> Rheumatoid Arthritis           | <input type="checkbox"/> Cancer ( What kind) _____    |
| <input type="checkbox"/> <b>Glaucoma</b>               | <input type="checkbox"/> <b>Depression</b> _____        | <b>Trauma:</b> _____                                  |
| <input type="checkbox"/> <b>Fibromyalgia</b>           | <input type="checkbox"/> <b>Other</b> _____             | <input type="checkbox"/> <b>Other</b> _____           |

## Surgical History: Check here if none ( )

- Low Back Surgery (when)** \_\_\_\_\_  Where \_\_\_\_\_  Surgeon \_\_\_\_\_
- Neck Surgery (when)** \_\_\_\_\_  Where \_\_\_\_\_  Surgeon \_\_\_\_\_
- Heart surgery ( year)** \_\_\_\_\_  **Cancer surgery** \_\_\_\_\_
- Joint replacement ( which) \_\_\_\_\_
- Appendix  Hernia  Galbladder  Hysterectomy  **OTHER SURGERY** \_\_\_\_\_

## Allergies:

- Foods \_\_\_\_\_  Shellfish
- Pennicillin  Sulfa  **Iodine**  **I V Dye**  **Latex**  Adhesive Tape
- Others \_\_\_\_\_

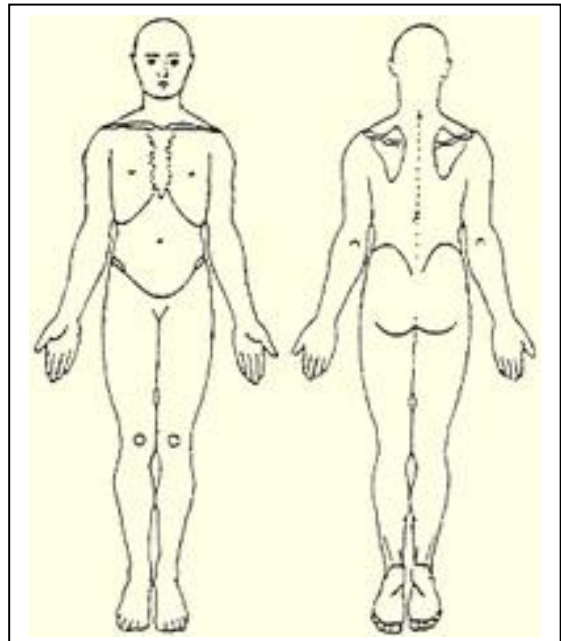
**Pain in the lower back/ neck:** 0 1 2 3 4 5 6 7 8 9 10

## Current Medications:

**Pain in the arm/ leg:** 0 1 2 3 4 5 6 7 8 9 10

Name of drug	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Pls draw/ color  
painful area**



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Name: \_\_\_\_\_ Date \_\_\_\_\_ PCP \_\_\_\_\_  
 Ref MD. \_\_\_\_\_

**Chief Complaint:**  
**History of Present Illness:**

**Pain History:**    0    1    2    3    4    5    6    7    8    9    10

**Constant**                      **Intermittent**  
**Character:**    dull/achy                      burning/ jabbing                      sharp                      shooting                      throbbing                      pressure                      electric

**Location:** LBP                      SIJ                      hip                      thigh                      knee                      calf                      ankle                      top foot                      heel                      other  
    Neck                      scap                      Shldr                      arm                      forearm                      wrist                      hand                      fingers #

**Right:**  
**Left:**

**Increased by:**    sit/drive                                      standing/walking                                      position change                                      activity    rest                      everything  
**Decreased by:**    sitting                                      lying in bed                                      Stnd/Mov stretch                                      heat/ice/meds

*Low Back Pain %:*                                      *Sciatica (limb Pain) %:*

**LABS/ X RAYS:**    **Decr T2**                      **Disc Ht**                      **Sp St**                      **HNP**                      **Foramen**                      **other**

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**Exam:**                      ( ) **Check here if everything below is normal except for the positive findings checked off.**

Resp Rate: \_\_\_\_\_ Pulse \_\_\_\_\_ Temp \_\_\_\_\_ ( ) Alert ( ) Oriented

**NEURO:**                      Cranial Nerves    II–XII                      (NI to gross Insp)                      ( Abnl )  
    coordination                      balance                      rhomberg                      **GAIT NI / ABNL**                      **REFLEXES**

**STRENGTH:**                      **Arms/ Legs**                      **NL/ ABNL**                      **R / L**

**SENS:**                      **Arms/ Legs**                      **NL/ ABNL**                      **R / L**

Coordination: Normal/ Abnormal :

**MSK**    ROM                      SGN                      CLUNEAL                      SIJ                      SSI                      SSN                      CTS

**FACET TENDERNESS**                      Cervical + / --                      Thoracic + / --                      Lumbar + / --

**EXTREMITIES:**                      Edema UE/LE                      Atrophy UE/LE

**HEENT:** conjunctivae eyes wnl/abnr oral cavity wnl/abnr

**Affect:** normal/flat    obviously depressed    yes/no

**SKIN SYSTEM:** Nr/abnr    arms/legs    Palpation skin etc:

**NECK:** masses    insp    normal/abnr

**CHEST:** CTA wnl / abnr    (Rhonchi/crepitations)    symmetrical

**CVS:**                      S1                      S2                      +O

**Abdomen:** soft    NT    Masses Y/N    Bowel Sounds + / --

**Lymph Nodes:** Neck + / --                      Axillae + / --                      Groin + / --

**VASCULAR:**                      VARICOSITIES                      Yes / NO                      PULSES Radial / Pedal                      NL/ ABNL                      Right/ Left.

**IMPRESSION:**

- 1.
- 2.
- 3.
- 4.

Lortab	Naprosyn	Soma
Percocet	Celebrex	Flexeril 10 mg
MSIR	Medrol Dose pack	Zanaflex 4 mg
	Darvocet	Skelaxin
		Elavil 25 mg
		Lyrica
		Neurontin

**PLAN:**

MS Contin/Oxycontin  
 \*pt counseled not to crush/chew/break  
Duragesic  
 \*pt cautioned re: sun exposure/tanning bed use

MRI C/T/L

X-rays C/T/L

FOLLOW UP =

Biomechanics discussed & patient education done                      smoking cessation emphasized  
**DRUG ADDICTION/DEPENDENCE DISCUSSED**                      WORK STATUS = Light/Moderate/Regular/Sedentary