UNC HOSPITALS

MIM#: Pilot

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UNC Hospitals Spine Center
1350 Raleigh Road, Chapel Hill, NC 27517

New Patient Questionnaire

General Medical Information:

What is your main problem? Low Back Pain Neck Pain Leg Pain Arm Pain Other _____

Primary Care Physician **and** Referring Doctor Name: _____

On a scale of 0-10, how would you rate your pain? _____

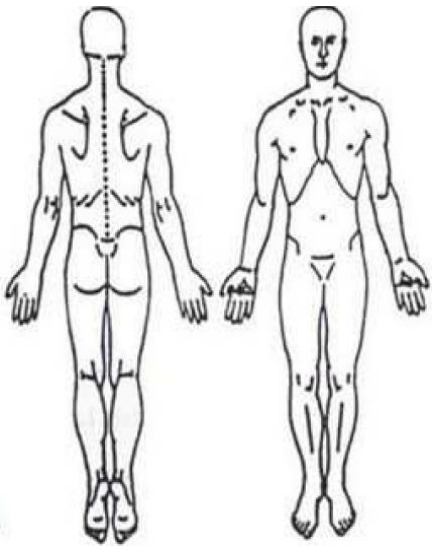
Please describe your current complaint:

1. **How did your problem start?** **Date of Onset:** _____
   Gradually Suddenly Accident/Injury Other _____
2. **What type of pain/symptoms?**
   Numbness Weakness Tingling Stiffness Swelling Other _____
3. **Have you experienced any loss of bowel or bladder control?**
   Yes No
4. **What worsens your problem?**
   Exercise Sitting/Lying Down Standing Walking Stairs Other _____
5. **How often do you have pain?**
   Getting Better Constant Intermittant Getting Worse No Pain Other _____
6. **What helps your pain?**
   Pain Medication Massage Heat Ice Nothing Other _____
7. **Have you had any of the following treatment for your current problem?**
   Physical Therapy Medication Injections Surgery Chiropractic Treatments
8. **Have you had any of the following tests for your current problem within the last 7 years?**
   MRI X-Rays CT Scan Other: _____
   Did you bring them with you? Yes No
9. **Will your visit involve Workman's Compensation?**
   Yes No
10. **If this is the result of an accident/injury, are you involved in a lawsuit or have a lawyer?**
    Yes No

Please identify CURRENT painful areas in your body by **MARKING** appropriate areas:

Please tell us more about the pain areas/weakness/numbness you are having:

_____
_____
_____
_____
_____
_____



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History:

Do you **OR** any of your family members have? (Please check all of the following that apply)

Self	Family		Self	Family	
____	____	Asthma/Emphysema/COPD	____	____	High Blood Pressure
____	____	Bleeding or Blood Clotting Problems	____	____	Osteoporosis
			____	____	Problems with Anesthesia
____	____	Cancer/Type _____	____	____	Stomach Ulcers
____	____	Diabetes	____	____	Seizures
____	____	Heart Attack/Disease/Stroke	____	____	Thyroid Disease
			____	____	Other _____

Please list any previous surgeries you have had:

_____ Date: _____

_____ Date: _____

Have you had **any** of the following in the past 6 months? (Please answer all of the following)

Yes	No		Yes	No	
____	____	Arthritis	____	____	Loss of Bowel Control
____	____	Blood in Urine	____	____	Nausea/Vomitting
____	____	Bloody or Black stool	____	____	Pneumonia
____	____	Chest Pain	____	____	Recent Fever or Chills
____	____	Depression/Mood Changes	____	____	Shortness of Breath
____	____	Difficulty Uriniating	____	____	Skin Changes
____	____	Difficulty Walking	____	____	Stomach Pain
____	____	Easy Bleeding	____	____	Swelling of Arms or Legs
____	____	Easy Bruising	____	____	Swollen Joints
____	____	Fatigue	____	____	Tuberculosis
____	____	Headaches or Dizziness	____	____	Unintentional Weight Change
____	____	Loss of Bladder Control	____	____	Vision or Hearing Changes
			____	____	Other _____

Social History:

What is your marital status: Single Married Divorced Widowed

How many children do you have? _____

Are you currently working? Full Time Part Time Not Working Retired

Occupation: _____

What do you do for exercise? _____ How often? _____

Do you use tobacco products? Yes No Quit? _____ Packs per day?_____

Do you drink alcohol? Yes No Quit? _____ Drinks per day? _____

Do you use recreational drugs? Yes No Quit? _____ How often? _____

Drug or alcohol dependancy? Yes No

Patient Signature: _____ **Date:** _____ **Time:** _____