

Spine Surgery Center

A Baylor-HealthTexas Affiliate

BACK

Matthew Berchuck, M.D.

Height: ____ ft ____ in

Patient Name: _____

Weight: _____ lb

Age: _____

Occupation: _____

History of Present Illness

In your own words, describe the problem you are having?

I was referred by: _____

Primary Care Physician (If different): _____

When did your present pain start? _____

Was this an injury? Yes No Describe: _____

Were you injured at work? Yes No Have you/will you file a worker's compensation claim? Yes No

On a scale from 0 (no pain) to 10 (unbearable pain) my pain is currently a _____

How long have you had this pain? _____ years _____ months _____ weeks _____ days

How long have you had similar pain? _____ years _____ months _____ weeks _____ days

Are you having any leg pain? Yes No

My leg pain is greater than less than equal to my back pain.

Leg Symptoms:

Right: Numbness? Yes No Weakness? Yes No Tingling? Yes No

Left: Numbness? Yes No Weakness? Yes No Tingling? Yes No

Do your symptoms awaken you at night? Yes No Sometimes

How far can you walk? _____

Are you having any problems with bowel, bladder or sexual function?

Describe: _____

Have you been losing weight (OTHER THAN DIETING)? Yes No

If yes, how much weight was lost? _____

Treatments:

Medications: _____

Physical therapy Injections Other: _____

My symptoms are getting: better worse about the same

My symptoms are: present everyday constant present occasionally

Previous BACK Surgery: (Please indicate year, type of Surgery, and Surgeon, if known)

1. _____
2. _____
3. _____

Testing done:

X-rays MRI EMG/NCV
 Myelogram with CAT Scan CAT Scan Other: _____

Do you have any additional information that would be helpful to understand your problem?

Medical History

Do you have any history of:						<input type="checkbox"/> None of the following			
AIDS/HIV	Yes	No	Kidney Problems	Yes	No	Stomach Prob(Ulcers, Reflux)	Yes	No	
Migraine Headache	Yes	No	High Blood Pressure	Yes	No	Thyroid Disorder	Yes	No	
Anemia	Yes	No	Muscle Diseases	Yes	No	Breast Cancer	Yes	No	
Arthritis	Yes	No	COPD	Yes	No	Prostate Cancer	Yes	No	
Diabetes	Yes	No	Liver disease	Yes	No	Lung Cancer	Yes	No	
Epilepsy/Seizure	Yes	No	Hepatitis A/B/C	Yes	No	Thyroid Cancer	Yes	No	
Gout	Yes	No	Osteoporosis/Osteopenia	Yes	No	Myeloma	Yes	No	
Cancer	Yes	No	Nerve Problems	Yes	No	Lymphoma	Yes	No	
Bleeding Problems	Yes	No	Pneumonia	Yes	No	Problems with Anesthesia	Yes	No	
Emphysema/Asthma	Yes	No	Psychiatric Disorders	Yes	No	Blood Clots (DVT,PE)	Yes	No	
Fibromyalgia	Yes	No	Depression/Anxiety	Yes	No	Rheumatoid Arthritis	Yes	No	
Irregular Heartbeat	Yes	No	Stroke	Yes	No	Sleep Apnea	Yes	No	
Heart Problems	Yes	No	Polio	Yes	No	Other	Yes	_____	

Review of Systems

Do you have any complaints of:						<input type="checkbox"/> None of the following			
Chest Pain	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	Abnormal Menstrual Cycle	<input type="checkbox"/>		
Cough	<input type="checkbox"/>	Cold Hands/Feet	<input type="checkbox"/>	Growth Disturbance	<input type="checkbox"/>	Incontinence of Bowel	<input type="checkbox"/>		
Depression	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>	Incontinence of Urine	<input type="checkbox"/>		
Ear Pain	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>	Numbness of Feet	<input type="checkbox"/>	Sleep Disturbance	<input type="checkbox"/>		
Fainting	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	Numbness of Hands	<input type="checkbox"/>	Sputum Production	<input type="checkbox"/>		
Fever	<input type="checkbox"/>	Balance Problems	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Visual Disturbance	<input type="checkbox"/>		
Mania	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Sore Throat	<input type="checkbox"/>	Swelling in the Legs	<input type="checkbox"/>		
Skin Rash	<input type="checkbox"/>	Skin Ulcers	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	Unexplained Weight Loss	<input type="checkbox"/>		
Vomiting	<input type="checkbox"/>	Stomach Pain	<input type="checkbox"/>	Weight Gain	<input type="checkbox"/>	Other	_____		

