Spine Surgery Center
A Baylor-HealthTexas Affiliate

Matthew Berchuck, M.D.

Neck

Date:_____

Height: _____ft ____ in
Weight: _____ lbs

Patient Name: _____**DOB:** _____

History of Present Illness

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

_____

_____

Referring Doctor: _____

Primary Care Physician (If different):_____

What date (roughly at least) did your present pain start? _____

Was this an injury? Yes No Work-related? Yes No Sports-related? Yes No

No apparent cause? Yes No Auto Accident? Yes No Other:_____

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

Mechanism of pain onset:

□ Suddenly □ Lifting □ Falling □ Pulling

□ Gradually □ Twisting □ Bending □ Hit from behind

Are you having any shoulder or arm pain? Yes No Is your arm pain increased with coughing or wheezing? Yes No

What is the distribution of your arm pain? _____

Does it involve any of your fingers? Right: _____ Left: _____

Arm Symptoms:

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

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

My arm symptoms are □ greater than □ less than □ equal to my

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: _____

_____

Treatments received thus far:

□ Anti-inflammatory medication □ Neck Brace □ Chiropractic Manipulation (dates) _____

□ Physical therapy □ Injection □ Other: _____

My symptoms are getting: □ better □ worse □ about the same

My symptoms are: □ present everyday □ constant □ present occasionally

Testing done thus far:

□ Diagnostic x-rays □ MRI □ EMG □ Other: _____

□ Myelogram □ CAT Scan □ Discogram _____

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

_____

_____

Medical History

Do you have any history of:						□None of the following/No to all		
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	Problems with Anesthesia	Yes	No
Bleeding Problems	Yes	No	Pneumonia	Yes	No	Blood Clots (DVT,PE)	Yes	No
Emphysema/Asthma	Yes	No	Psychiatric Disorders	Yes	No	Rheumatoid Arthritis	Yes	No
Fibromyalgia	Yes	No	Depression/Anxiety	Yes	No	Sleep Apnea	Yes	No
Irregular Heartbeat	Yes	No	Stroke	Yes	No	Other	Yes	_____
Heart Problems	Yes	No	Polio	Yes	No			

Patient Name: _____

Review of Systems

Do you have any complaints of:						□None of the following/No to all	
Chest Pain	□	Constipation	□	Abnormal Bleeding	□	Abnormal Menstrual Cycle	□
Cough	□	Cold Hands/Feet	□	Growth Disturbance	□	Incontinence of Bowel	□
Depression	□	Loss of Appetite	□	Runny Nose	□	Incontinence of Urine	□
Ear Pain	□	Muscle Weakness	□	Numbness of Feet	□	Sleep Disturbance	□
Fainting	□	Impotence	□	Numbness of Hands	□	Sputum Production	□
Fever	□	Balance Problems	□	Shortness of Breath	□	Visual Disturbance	□
Mania	□	Seizures	□	Sore Throat	□	Swelling in the Legs	□
Skin Rash	□	Skin Ulcers	□	Wheezing	□	Unexplained Weight Loss	□
Vomiting	□	Stomach Pain	□	Weight Gain	□	Other _____	

Current Medications (Name and dosage) □ **None**

Do you take antacids? Yes No	

Allergies to Medications:

□ None identified	

What surgeries/hospitalizations have you had in the past? What year were they done?

Have you had a major injury? Yes No	If so, what?

Social History

Do you smoke? Yes No Packs/day?_____ Smokeless varieties_____
How many years have you or did you smoke? _____ When did you quit? _____
Do you drink alcohol? Yes No How much? □Daily □____/week
Marital History: M S D W
Occupation _____ Employer_____
Are you currently working? Yes No If not, how long have you been off?_____
Please fill in last grade completed in school: _____

Family History

Does anyone in your family have:							
Osteoporosis/Osteopenia?	Yes	No	Blood Clots?	Yes	No		
Diabetes?	Yes	No	Arthritis?	Yes	No	What joints?	_____
High Blood Pressure?	Yes	No	Cancer?	Yes	No	What type?	_____
Heart Disease?	Yes	No	Tuberculosis	Yes	No		
Mental Disorder	Yes	No					