Donald S. Corenman, MD
New Patient Lumbar Spine History

Date: ☐☐ / ☐☐ / ☐☐☐☐

Please PRINT and fill out completely.

Shade circles like this: ●

Med record # ☐☐☐☐☐☐

Name _____ **Age** _____ yrs. **D.O.B.**_____

Height ☐ ft ☐☐ in **Weight** ☐☐☐ lbs **Sex** ○ Male ○ Female **Are you or could you be pregnant?** ○ Yes ○ No

Your Occupation _____ **Employer** _____

Who referred you to this office? If more than one, please note.
○ Dr. _____ ○ PA/NP _____
○ Friend/Word of Mouth _____ ○ Physical Therapist _____
○ Family Member _____ ○ Other _____

HISTORY OF CARE

Who is your primary care physician? _____ **Location:** _____
Address: _____ **Phone:** _____

Please list any other doctors, clinics, or hospitals you have seen for your current spinal problems:

Name	*City*	*Date of First Visit*	*Currently Continuing?*

HISTORY OF CURRENT SPINAL PROBLEMS

List your chief complaints or main problems with the most severe first:
1. _____
2. _____
3. _____

Describe all details of any accident, incident or the way these problems began:
_____
_____
_____
_____

CURRENT SYMPTOMS

What time of day is your pain at its worst? ○ Morning ○ Afternoon ○ Evening ○ Night ○ Not Applicable

Does the pain wake you up at night? ○ Yes ○ No

In the past six months have you experienced: ○ Fever ○ Weight Loss _____ lbs ○ Chills ○ Night Sweats

How would you describe your pain? ○ Constant ○ Constant, but worse with activity ○ Intermittent (comes and goes) ○ Intermittent, but worse with activity

Do you have full control of your bladder? ○ Yes ○ No

Do you have full control of your bowels? ○ Yes ○ No

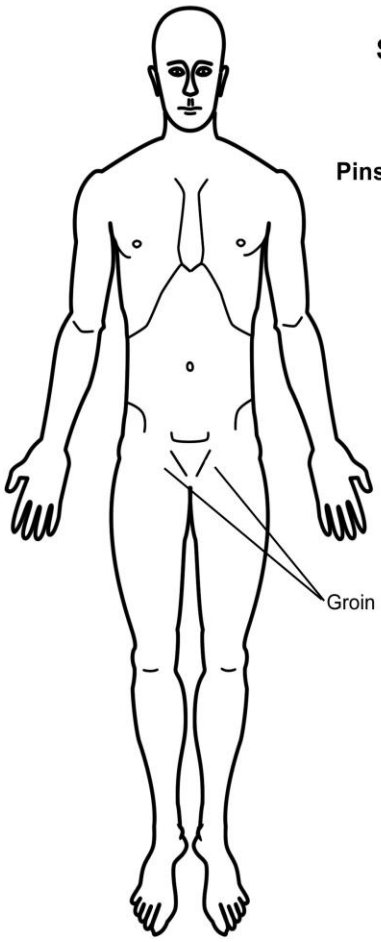
PATIENT PAIN DRAWING

Please mark the areas on your body where you feel the pain and/or sensations described below, using the appropriate symbol as indicated. Mark the areas where your pain radiates, include all affected areas.

For Doctor Use Only

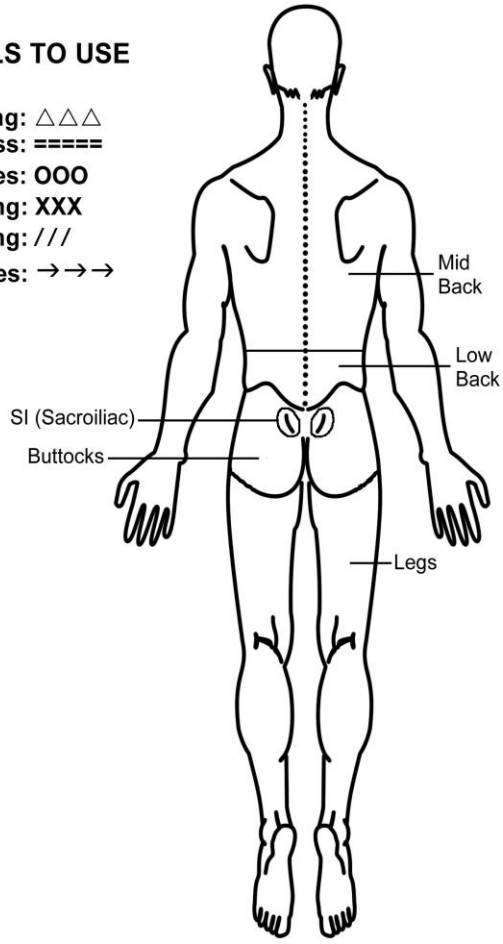
	R	L	Both/axial
Head			
Neck			
Trap			
Scap			
Scp/ Arm			
Arm			
LB			
LB/SI			
SI			
Bt/Leg			
M Bk			
Groin			

Complex ○ Positional ○



SYMBOLS TO USE

Aching: △△△
Numbness: =====
Pins & Needles: OOO
Burning: XXX
Stabbing: ///
Radiates: →→→



For Dr. Use Only
MB ○ Positional
LB ○ Positional
SI ○ Positional
Buttock ○ Positional
Gr ○ Positional
Lg ○ Positional

Mark where any symptoms (pain, numbness, weakness, etc.) exist on average (most of the time) and at their worst.

		None										Unbearable
Current **mid back** pain	**Average**	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
	Worst	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Current **low back** pain	**Average**	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
	Worst	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Current **SI** pain	**Average**	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
	Worst	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Current **buttock**	**Average**	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
	Worst	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Current **groin** pain	**Average**	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
	Worst	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Current **leg** pain	**Average**	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
	Worst	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10

PAST MEDICAL HISTORY

Check if you currently are being treated for or have been diagnosed with:

	When?		*When?*
○ High Blood Pressure		○ Osteoporosis	
○ Diabetes		○ Kidney Disease/Problem	
○ Liver Disease		○ Seizures	
○ Heart Disease or Attack		○ Arthritis	
○ Stroke		○ Thyroid	
○ Cancer _____		○ Tuberculosis	
○ High Lipids (cholesterol, etc.)		○ Psoriasis	
○ Ulcer Disease		○ Polio	
○ Gastritis		○ Rheumatic Fever	
○ Reflux Disease (GERD)		○ Gout	
○ Asthma		○ Herpes Simplex	
○ Depression		○ **Other**	
○ Bipolar Disease			
○ Other Psychiatric			

Have you ever had a history of blood clots or pulmonary embolus? ○ Yes ○ No

SURGERIES

Please list all ***spine* surgeries you have had in the past:**

Type of Surgery	*Date*	*Surgeon*

Please list all ***other* surgeries you have had in the past:**

Type of Surgery	*Date*	*Surgeon*

MEDICATIONS

Please list ALL medications you are ***currently* taking, including prescription and over the counter:**

Medication	*Dosage*	*Frequency (how many pills in a 24 hours)*

ALLERGIES

Please list any ***allergies or adverse reactions* you have to medications:**

Medication	*What Happened?*

FAMILY HISTORY

Is your father alive? ○ Yes ○ No **IF YES, age and any major medical problems?** _____

IF NO, age at time of death? _____ **What major medical problems did he have?** _____

Is your mother alive? ○ Yes ○ No **IF YES, age and any major medical problems?** _____

IF NO, age at time of death? _____ **What major medical problems did she have?** _____

Any siblings? ○ Yes ○ No **How many?**

SOCIAL HISTORY

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed ○ Living with other

Education level achieved: ○ Grade School ○ Jr. High ○ High School ○ College ○ Post. Graduate

***DO* you currently smoke cigarettes?** ○ Yes ○ No **Number of Years Smoked:** ☐☐ **For Dr. Use Only** p yrs ☐☐☐

Packs per Day: *(Please choose the closest)* ○ < 1/2 ○ 1/2 ○ 1 ○ 2 ○ > 2

***DID* you smoke cigarettes in the past?** ○ Yes ○ No **Number of Years Smoked:** ☐☐ **Quit Date:** ☐☐ / ☐☐ / ☐☐☐☐

Packs per Day: *(Please choose the closest)* ○ < 1/2 ○ 1/2 ○ 1 ○ 2 ○ > 2

Do you use any other tobacco products? ○ Yes ○ No **What kind?** _____ **Quantity:** _____

Do you use any recreational drugs? ○ Yes ○ No **What kind?** _____

Do you drink alcohol? ○ Yes ○ No **Drinks per Day:** ☐☐ **Drinks per Week:** ☐☐ **Years:**

***DO YOU HAVE OR HAVE YOU HAD* an unhealthy relationship with alcohol?** ○ Yes ○ No

Type of alcohol consumption: ○ Beer ○ Wine ○ Mixed Drinks

WORK HISTORY

Are you currently: ○ employed ○ unemployed ○ retired ○ on sick leave ○ on disability ○ a stay at home parent

Has your job changed since your symptoms started? ○ Yes ○ No ○ Not Working

If you are at a different job or not working, did your symptoms play a role in your job change or decision not to work? ○ Yes ○ No

If you are working, are you on: ○ Normal duties ○ Light duties

If you are on light duty, did your current symptoms play a role? ○ Yes ○ No

Are you applying for disability? ○ Yes ○ No

Please describe your job _____

WORKMAN'S COMPENSATION HISTORY

IS THIS A WORKERS COMPENSATION CASE? ○ Yes ○ No

Have you had any PRIOR workers compensation injuries? ○ Yes ○ No **If yes, how many?** ☐☐

Please list any prior workers compensation cases/injuries:

Date	*Area Injured*	*Time off Work*	*Who Treated You?*

Were you at work when your symptoms began? ○ Yes ○ No

Did you have a specific accident or injury while at work to cause your symptoms? ○ Yes ○ No

What is the company name? _____

Prior to your WC injury, how long had you been employed by that company? ☐☐ **months OR** ☐☐ **years**

Do you currently have an attorney for this episode? ○ Yes ○ No

CAR ACCIDENTS

WERE YOUR SYMPTOMS CAUSED BY A CAR ACCIDENT? ○ Yes ○ No

Have you had any PRIOR car accidents? ○ Yes ○ No **If yes, how many?** ☐☐

Please list:

Date	*Area Injured*	*Time off Work*	*Who Treated You?*

Do you currently have an attorney for this episode? ○ Yes ○ No

REVIEW OF SYSTEMS

Check No or Yes in the following areas. If "Yes," please describe:

1. CONSTITUTIONAL

- **A. Recent weight change?** ○ Yes ○ No _____
- **B. Change or loss of appetite?** ○ Yes ○ No _____
- **C. Fevers?** ○ Yes ○ No _____
- **D. Chills?** ○ Yes ○ No _____
- **E. Night sweats?** ○ Yes ○ No _____
- **F. Weakness fatigue** ○ Yes ○ No _____

2. EYES

- **A. Vision change?** ○ Yes ○ No _____
- **B. Glasses/contacts?** ○ Yes ○ No _____
- **C. Glaucoma?** ○ Yes ○ No _____
- **D. Eye infections (iritis)?** ○ Yes ○ No _____
- **E. Loss of vision?** ○ Yes ○ No _____

3. EARS, NOSE, AND THROAT

- **A. Decrease or loss of hearing?** ○ Yes ○ No _____
- **B. Ear ache or infection?** ○ Yes ○ No _____
- **C. Tinnitus (ringing in ear)?** ○ Yes ○ No _____
- **D. Nasal stuffiness/discharge?** ○ Yes ○ No _____
- **E. Nosebleeds?** ○ Yes ○ No _____
- **F. Sore throat?** ○ Yes ○ No _____
- **G. Hoarseness?** ○ Yes ○ No _____
- **H. Dental problems?** ○ Yes ○ No _____
- **I. Dentures?** ○ Yes ○ No _____
- **J. Difficult swallowing?** ○ Yes ○ No _____

4. CARDIOVASCULAR

- **A. Chest pain?** ○ Yes ○ No _____
- **B. Shortness of breath?** ○ Yes ○ No _____
- **C. Palpitations?** ○ Yes ○ No _____
- **D. Swelling in the legs?** ○ Yes ○ No _____
- **E. PLEASE LIST MOST RECENT HEART TESTS WITH NAME OF FACILITY, DATE, AND CONTACT PHONE NUMBER**

_____

5. RESPIRATORY

- **A. Cough?** ○ Yes ○ No _____
- **B. Wheezing/asthma?** ○ Yes ○ No _____
- **C. Pneumonia or bronchitis?** ○ Yes ○ No _____
- **D. Shortness of breath?** ○ Yes ○ No _____

6. GASTROINTESTINAL

A. Abdominal pain?	○ Yes	○ No	
B. Nausea or vomiting?	○ Yes	○ No	
C. Constipation?	○ Yes	○ No	
D. Diarrhea?	○ Yes	○ No	
E. Heartburn/acid reflux?	○ Yes	○ No	
F. Rectal bleeding or black, tarry stools?	○ Yes	○ No	

7. GENITOURINARY

A. Increase frequency of urination?	○ Yes	○ No	
B. Pain/burning when you urinate?	○ Yes	○ No	
C. Frequent infection of urine?	○ Yes	○ No	
D. Incontinence (loss of control)?	○ Yes	○ No	
E. Reduced force of urination?	○ Yes	○ No	

8. MUSCULOSKELETAL

A. Muscle aches?	○ Yes	○ No	
B. Joint pains/stiffness (arthritis)?	○ Yes	○ No	
C. Swelling of joints?	○ Yes	○ No	

9. SKIN

A. Rash?	○ Yes	○ No	
B. Lumps or sores?	○ Yes	○ No	
C. Changes in hair or nails?	○ Yes	○ No	
D. Dryness?	○ Yes	○ No	
E. Ulcers?	○ Yes	○ No	
F. Abnormal scars?	○ Yes	○ No	

10. NEUROLOGICAL

A. Headaches?	○ Yes	○ No	
B. Fainting/blackouts?	○ Yes	○ No	
C. Tremors/involuntary movements?	○ Yes	○ No	
D. Numbness, tingling?	○ Yes	○ No	
E. Dizziness?	○ Yes	○ No	
F. Muscle weakness?	○ Yes	○ No	

11. PSYCHIATRIC

A. Depression?	○ Yes	○ No	
B. Mood swings?	○ Yes	○ No	
C. Anger?	○ Yes	○ No	
D. Nervousness/anxiety?	○ Yes	○ No	

12. ENDOCRINE

A. Excessive thirst or hunger?	○ Yes	○ No	
B. Hot/cold intolerance?	○ Yes	○ No	
C. Hot flashes?	○ Yes	○ No	

13. HEMATOLOGICAL

A. Easy bruising or bleeding?	○ Yes	○ No	
B. Past blood transfusions?	○ Yes	○ No	