

# Nasa Spine Institute



## CERVICAL SPINE BOOKLET

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

DOB: \_\_\_\_\_

FAMILY DOCTOR: \_\_\_\_\_

MARK THESE DRAWINGS USING THE SYMBOL THAT BEST DESCRIBES YOUR PAIN

Numbness: =====

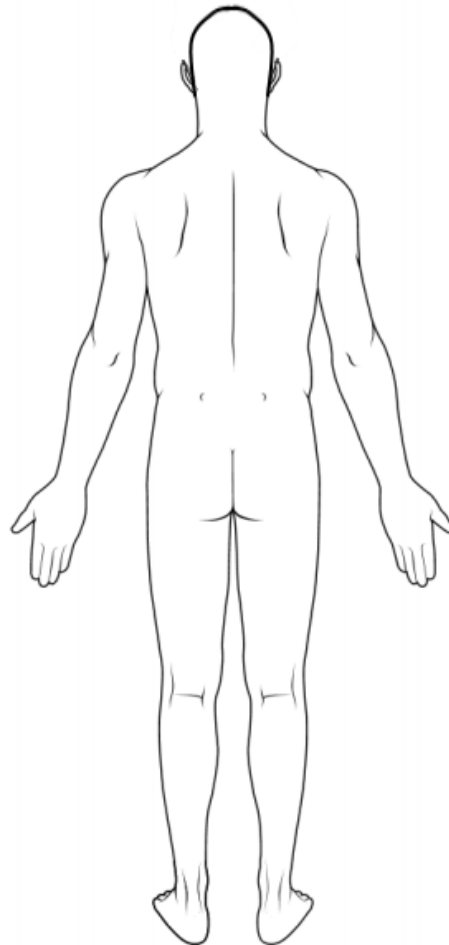
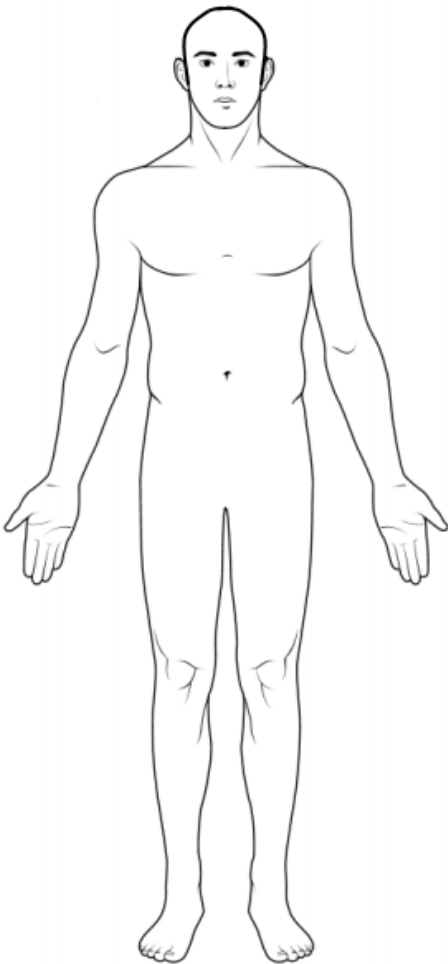
Ache: UUUUUUUU

Pins and Needles: 00000000

Stabbing: //////////////

Burning: XXXXXXXX

Cramping: ++++++++



RIGHT

LEFT

LEFT

RIGHT



9. How long can you sit in a chair?

Less than 5 minutes \_\_\_\_\_ 5-15 minutes \_\_\_\_\_ 15-30 minutes \_\_\_\_\_  
30-60 minutes \_\_\_\_\_ as long as I want \_\_\_\_\_

How do your symptoms affect your life?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you use a cane, walker or wheelchair? \_\_\_\_\_

10. Do your symptoms affect your sleep?  YES  NO

How long do you sleep before your symptoms wake you? \_\_\_\_\_

Do you take medication to help you sleep?  YES  NO

Medication used to sleep? \_\_\_\_\_

11. Due to your symptoms do you need help with activities of daily living?  YES  NO

Explain: \_\_\_\_\_  
\_\_\_\_\_

12. Have you missed any work due to spinal problems?  YES  NO

How much work have you missed? \_\_\_\_\_

Date you last worked? \_\_\_\_\_

Do your symptoms affect your work?  YES  NO

Explain: \_\_\_\_\_  
\_\_\_\_\_

Do you take medication for your symptoms while at work?  YES  NO

What medications? \_\_\_\_\_  
\_\_\_\_\_

13. Have you had an MRI of your neck? When? \_\_\_\_\_ Where? \_\_\_\_\_

CT Scan? \_\_\_\_\_ Myelogram? \_\_\_\_\_

X-rays? \_\_\_\_\_ EMG/Nerve conduction studies? \_\_\_\_\_

**MEDICAL HISTORY:**

**MEDICAL PROBLEMS FOR WHICH YOU TAKE MEDICATIONS:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

**MEDICAL PROBLEMS FOR WHICH YOU DO NOT TAKE MEDICATIONS:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

DO YOU TAKE ASPIRIN OR PRODUCTS CONTAINING ASPIRIN?  YES  NO

DO YOU TAKE OVER THE COUNTER NSAID (MOTRIN, ADVIL, ALEVE, ETC)?  YES  NO

HAVE YOU EVER HAD BLOOD CLOTS?  YES  NO

**ALLERGIES TO MEDICATIONS:**

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

*If you are not allergic to any medications, please check*  NONE

**SURGERIES:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

DO YOU BLEED EXCESSIVELY WITH DENTAL WORK OR WITH SURGERY OR WITH MINOR INJURIES?  YES  NO

HAVE YOU EVER BEEN ON CHRONIC PAIN MEDICATIONS?  YES  NO

WHAT PAIN MEDICINE HAS WORKED WELL FOR YOU IN THE PAST?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

LIST ALL MEDICATIONS AND VITAMINS

- |           |           |
|-----------|-----------|
| 1. _____  | 16. _____ |
| 2. _____  | 17. _____ |
| 3. _____  | 18. _____ |
| 4. _____  | 19. _____ |
| 5. _____  | 20. _____ |
| 6. _____  | 21. _____ |
| 7. _____  | 22. _____ |
| 8. _____  | 23. _____ |
| 9. _____  | 24. _____ |
| 10. _____ | 25. _____ |
| 11. _____ | 26. _____ |
| 12. _____ | 27. _____ |
| 13. _____ | 28. _____ |
| 14. _____ | 29. _____ |
| 15. _____ | 30. _____ |

**Social History:**

Do you drink alcoholic beverages?  Yes  No

How much per day/week? \_\_\_\_\_

Do you drink alcohol to control your pain?  Yes  No How much? \_\_\_\_\_

Do you smoke or use tobacco in any form?  Yes  No

What form and how much per day? \_\_\_\_\_

Are you currently working?  Full-time  Part-time  Not working

What type of work do you do? \_\_\_\_\_

Are you experiencing financial difficulties due to your spine-related problems?  Yes  No

Retired? (What age) \_\_\_\_\_

Disabled? (What age and year and the reason) \_\_\_\_\_

Marital status?  Married  Single  Divorced  Widow

Living arrangement?  Alone  With family  With friends  Other

Does your pain affect your social and recreational life?  Yes  No

How and what activities? \_\_\_\_\_

Has your pain affected your sex life?  Unchanged  Extra pain  Very painful

Severely restricted  Nearly absent  Prevents any sex at all

**Family History:**

Mother

Father

Brothers

Sisters

Children

Heart Disease: \_\_\_\_\_

Hypertension: \_\_\_\_\_

Stroke: \_\_\_\_\_

Cancer: \_\_\_\_\_

Diabetes: \_\_\_\_\_

Glaucoma: \_\_\_\_\_

Epilepsy: \_\_\_\_\_

Bleeding Disorders: \_\_\_\_\_

Kidney Disease: \_\_\_\_\_

Thyroid Disease: \_\_\_\_\_

Mental Illness: \_\_\_\_\_

Osteoporosis: \_\_\_\_\_

Back Problems: \_\_\_\_\_

Living: \_\_\_\_\_

Deceased: \_\_\_\_\_

PLEASE CIRCLE THE ONES THAT APPLY

**Review of Systems:**

Weight: \_\_\_\_\_

Height: \_\_\_\_\_

General state of health  Good  Fair  Poor

Ability to conduct usual activities  Yes  No

Exercise tolerance  Good  Fair  Poor

Comments: \_\_\_\_\_

**Const. (Health in General)**  No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer.

Other: \_\_\_\_\_

**Ears, Nose, Mouth & Throat**  No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness.

Other: \_\_\_\_\_

**C-V (Heart & Blood Vessels)**  No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking.

Other: \_\_\_\_\_

**Resp. (Lungs & Breathing)**  No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray.

Other: \_\_\_\_\_

**GI (Stomach & Intestines)**  No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence.

Other: \_\_\_\_\_

**GU (Kidney & Bladder)**  No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence.

Other: \_\_\_\_\_

**MS (Muscles, Bones, Joints)**  No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain.

Other: \_\_\_\_\_

**Integ. (Skin, Hair & Breast)**  No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes.

Other: \_\_\_\_\_

**Neurologic (Brain & Nerves)**  No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other:

\_\_\_\_\_

**Psychiatric (Mood & Thinking)**  No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions.

Other: \_\_\_\_\_

**Endocrinologic (Glands)**  No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive.

Other: \_\_\_\_\_

**Hematologic (Blood/Lymph)**  No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas.

Other: \_\_\_\_\_

**Allergic/Immunologic**  No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV.

Other: \_\_\_\_\_