HOWARD B. COTLER, MD

Date:
Zip Code _____ Telephone Number _____ Date of Birth: _____

Gulf Coast Spine Care, Ltd.

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F			**AGE:**
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		**Occupation**:	
Referring doctor:	Address:		Phone #:_____ Fax #:_____
Primary care doctor:	Address:		Phone #:_____ Fax #:_____
Preferred Pharmacy:	Address:		Phone #:_____ Fax#:_____

PREVIOUS TREATMENT FOR BACK OR NECK

☐ ***NONE***

☐ **PHYSICIAN'S NAME:**_____

They prescribed:	NO HELP	SOME RELIEF	MUCH RELIEF
☐ **MEDICATIONS: (Give Names)**	☐	☐	☐
☐**Anti-inflammatories:**	☐	☐	☐
☐**Muscle Relaxers**	☐	☐	☐
☐**Pain Medications**	☐	☐	☐
☐**Others**	☐	☐	☐
☐ **Physical Therapy**	☐	☐	☐
☐ **Traction**	☐	☐	☐
☐ **Exercises**	☐	☐	☐
☐ **Injections: Describe**	☐	☐	☐
☐ **Manipulations (Osteopath)**	☐	☐	☐
☐ **Chiropractor's Name:**			
☐ **Heat** ☐ **Ice**	☐	☐	☐

☐ **SPINE SURGERY (Age _____) Describe:**

☐ **I have had the following test :**

☐ **Regular X-rays** ☐ **Discogram**
☐ **MRI** ☐ **EMG**
☐ **Myelogram** ☐ **OTHER:**

I have seen other doctors for my condition:

List types of doctors and who they were:

JOB HISTORY

☐**Heavy – Lifting over 60 lbs; frequent bending** ☐**Medium- Lifting 30-50 lbs**

☐**Light – Lifting 10-20 lbs** ☐**Sedentary- Sit most of the time; very little lifting** ☐ My job is high stress; it makes me tense.

PRESENT PROBLEM	
CHIEF COMPLAINT:	
How long have you had this problem?	
What caused the problem?	
Wha makes your symptoms worse?	
Do you have any weakness and if so where?	
Do you have any numbness and if so where?	
What other treatments have you had?	☐ Medication(s) ☐ Chiropractic care ☐Physical therapy ☐ Injections
Is this a work related problem?	
Is there any lawsuit regarding the injury?	
☐ Injury ☐ On the job	Explain how it happened:
☐ Date of injury:_____	
☐ I don' t know how it began	My problem is chronic: It began at age:
☐I remember an injury. Please describe:	
THE FOLLOWING MAKES MY DISCOMFORT *BETTER*:	
NECK: ☐Bed rest ☐Massage ☐Heat ☐Ice	☐Stretching/"popping" neck ☐ Nothing helps! ☐Other :
BACK: ☐Bed rest ☐ Decreased activities	☐ Bending forward ☐Bending backwards ☐ Nothing helps ☐Other :
THE FOLLOWING MAKES MY DISCOMFORT *WORSE*:	
NECK: ☐Activity ☐Bending neck Forward	☐Bending neck backward ☐Bending neck left ☐Bending neck right ☐Other:
BACK: ☐Activity ☐ Bending forward ☐ Bending Backward	☐Sitting ☐Standing ☐Walking ☐Sneeze/Cough/Strain to go to the bathroom ☐Other:

I ALSO HAVE THE FOLLOWING PROBLEMS

☐*Specific weakness* of muscles in my arms or hands

☐*Generalized weakness* of arms or hands due to pain or discomfort

☐Numbness in: ☐arms ☐hands ☐legs ☐feet ☐toes

☐Tingling in: ☐arms ☐hands ☐legs ☐feet ☐toes

☐*Specific weakness* of legs due to pain and discomfort

☐*Generalized weakness* of legs due to pain and discomfort

☐My legs ☐Fatigue ☐Hurt when walk too far.
☐ This is relieved by resting my legs
I can walk: ☐ Less than a block. ☐1-2 blocks ☐more than 3 blocks.

☐Trouble with my bladder (urine) ☐I can't empty bladder ☐Loss of urine (accidents)

☐Trouble with bowels: ☐Constipation ☐Loss of control (accidents)

☐My pain is worse at night!

☐My pain awakens me from sleep.

GENERAL MEDICAL HISTORY

☐ Stomach ulcers ☐GERD ☐Colon disease:	
Thyroid disease: ☐ Hypothyroid ☐Hyperthyroid	☐High Cholesterol
☐ Hypertension Medication:	☐ Liver disease Hepatitis:
☐ Diabetes ☐Insulin dependent Medication(s):	☐ Kidney disease
☐ Heart Disease ☐Valve disease	☐ Cancer Type?
Lung disease: ☐ Asthma ☐TB ☐ Emphysema ☐ Pneumonia	☐ Eye disease:
Blood disorders: ☐ Anemia ☐ Bleeding problems ☐ Leukemia	☐Seizures
☐ Arthritis: ☐ Degenerative ☐ Rheumatoid ☐ Gout	
☐ Depression ☐ Bipolar ☐Anxiety ☐ Other_____	

List any medical problems that other doctors have diagnosed

LADIES

☐ My periods are normal for me.	☐ I have been pregnant _____times; still born _____times.
☐ I have problems with menstrual periods.	☐ I have had _____vaginal deliveries; _____ C-sections.
☐ I have vaginal discharge.	☐ Problems with deliveries and pregnancies (describe):

I am ☐ menopausal ☐ post-menopausal

☐ I have vaginal bleeding after menopause

☐ Other problems you need to discuss with a doctor:

MEN

☐ I have problems with sexual function ☐ I have penis discharge

☐ Other problems you need to discuss with a doctor:

Past Surgical History

Year	Surgery	Hospital / Doctor
	Tonsillectomy	
	Appendectomy	
	Gall Bladder	
	Vasectomy Hysterectomy ☐ Total ☐ Partial	
	Prostate operation	
	Biopsy: result & type:	
	Other:	
	Other:	
	Other:	
	Other:	
	Other:	
	Other:	

☐ **NO SURGERY**

Other hospitalizations

Year	Reason	Hospital

Major Injuries

☐ **Auto or cycle accidents, etc. (describe):**

☐ **No Major injuries**

Medications (list your prescribed drugs)

Name the Drug	Dose (mg)	Frequency Taken	
			More Medications:
			☐Aspirin ☐Blood thinners

Allergies to medications

☐**Penicillin** *Reaction*:_____ ☐**Sulfa** *Reaction*:_____ ☐ **Keflex** *Reaction*:_____ ☐ **Codeine** *Reaction*:_____

Name the Drug	Reaction You Had	Name the Drug	Reaction You Had

SOCIAL HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day ☐ Chew/Dip tobacco - can/day	☐ # of years	☐ Or year quit		
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
Drugs	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
	If yes, are you trying for a pregnancy?			☐ Yes	☐ No
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls (in the past 6 months)?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father		☐ Deceased	**Children**	☐ M ☐ F	
Mother		☐ Deceased		☐ M ☐ F	
Sibling(s)	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	

Members of my family suffer with the following condition:

☐ Stroke ☐ High Blood pressure ☐ Diabetes ☐ Arthritis ☐ Heart Trouble ☐ Back problems ☐ Lung disease

☐ I don't know ☐ Cancer; type(s):_____ ☐ Other:_____

SYSTEMS REVIEW

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ **Constitutional** Fever Weight loss/gain	☐ **Chest / Heart** Chest pain Palpitations	☐ **Neurological** Memory changes Difficulty walking Slurred speech Numbness
☐ **Head / Neck** Neck pain Headaches	☐ **Back** Lower back pain	☐ **Endocrine** Cold/heat intolerance Excessive thirst
☐ **Ears / Nose** Hearing loss Ringing Nose bleeding	☐ **Gastrointestinal** Nausea/vomiting Abdominal pain Rectal bleeding	☐ **Hematological** Easy bleeding or bruising Lymph node swelling
☐ **Eyes** Eye pain/burning Loss of vision Double Vision	☐ **Genitourinary** Urinary frequency Burning with urination Sexual function problems	☐ **Psychiatric** Depression Anxiety Psychosis
☐ **Throat** Sore throat	☐ **Skin** Rashes or lesions:	☐ **Lungs** Shortness of breath Cough

MENTAL HEALTH

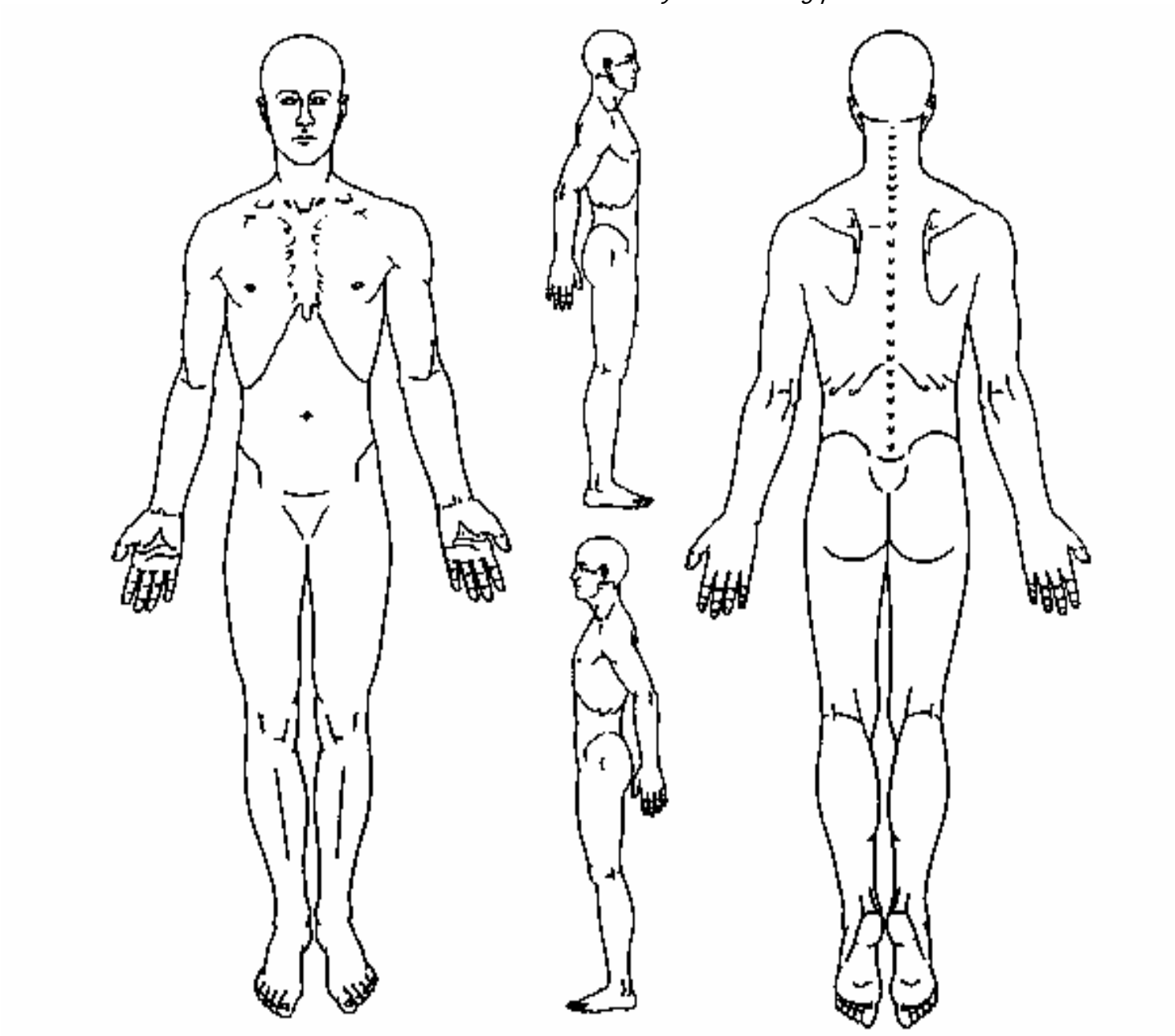
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No

Patient Signature _____ Date _____

Pain diagram

ACHE- AAA *NUMBNESS*- NNN *PINS & NEEDLES*- PPP *BURNING*- BBB *STABBING*-SSS

Please shade in the areas where you are having pain:



FRONT BACK

On a scale of 1-10 (with 10 being the most pain) please rate your pain TODAY:

Lower Back Pain		
Neck Pain		
Leg Pain	R	L
Arm Pain	R	L

Mid Back pain	