Beth Israel Lahey Health
Beth Israel Deaconess Hospital

PATIENT QUESTIONNAIRE: MEDICAL HISTORY

Spine Clinic

MR2044

Date: ____ / ____ / ____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other: _____ Sex Assigned at Birth: ☐ Male ☐ Female

Preferred Name: _____ Preferred Pronoun: ☐ He ☐ She ☐ They ☐ Other: _____

Primary Care Provider / Address: _____

Referring Provider / Address: _____

Reason for today's visit: _____

To whom do you want copies of your office notes sent: _____ ☐ N/A

Is your problem the result of an injury? ☐ No ☐ Yes **If No**, Skip to **PAIN section.**

If Yes, Date of injury: ____ / ____ / ____

Type of injury: ☐ Work-related ☐ Automobile ☐ Other (describe): _____

Are you currently represented by an attorney? ☐ No ☐ Yes Name: _____

Do you have worker's compensation? ☐ No ☐ Yes

PAIN

1. Use the symbol(s) from the Pain Symbol Key below to tell us the type of pain you are having.

Put the symbols on these places you have pain.

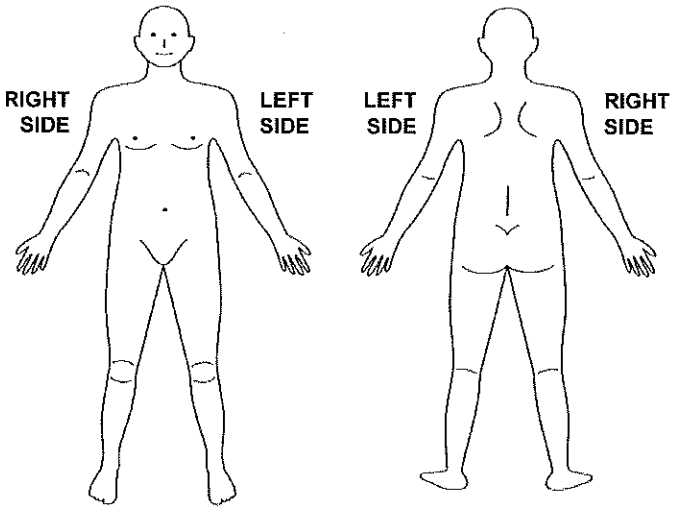
Example:

For sharp pain in your lower back, mark the spot on the "**BACK SIDE**" picture with the symbol: **S**

Pain Symbol Key:

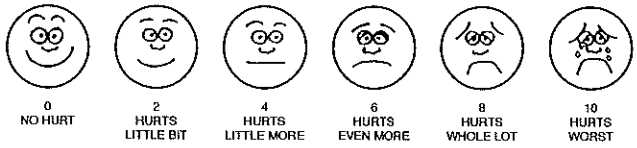
Ache = **A** Sharp = **S** Throbbing = **T**

Pins / Needles = **PN** Shooting = **H**



FRONT SIDE **BACK SIDE**

2. Use the Pain Scales below.



Circle the number that shows your pain level:

A. When you are resting:

0 1 2 3 4 5 6 7 8 9 10

B. When you are active:

0 1 2 3 4 5 6 7 8 9 10

3. How long have you had this problem: _____

4. What activities make the pain worse: _____

_____

5. What activities make the pain better: _____

_____

6. Have you been treated for this before?

☐ No ☐ Yes If **Yes**, what kind of treatments:

_____

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MEDICAL HISTORY Check either "**No**" or "**Yes**" for each of the following. For each "**Yes**", leave a comment.

	No	Yes	Comment:
Heart disease	☐	☐	
Angina / chest pain	☐	☐	
High blood pressure	☐	☐	
Heart murmur	☐	☐	
Mitral valve prolapse	☐	☐	
Lung disease	☐	☐	
Asthma	☐	☐	
Diabetes	☐	☐	
Cancer	☐	☐	
HIV / AIDS	☐	☐	

ALLERGY ☐ **I have no allergies or sensitivities that I know of.** ☐ **Yes If Yes,** list below.

Allergy / Sensitivity / Medication Reaction:	Type of Reaction:
Food:	
Latex:	
Medication:	
Contrast / dye:	
Evironmental:	
Other:	

MEDICATION ☐ **I take no medications or supplements.** ☐ **See attached list.**

List all the prescription and over-the-counter medications that you take at home (such as cold medication, herbals, vitamins, nutritional supplements or hormonal therapy). If you have received a printed medication list, please add here anything that is not on your printed list.

Medication / Supplement Name:	Dose:	How you take it: (by mouth, injection, etc.)	Time of day / How often:	Why you take it:

SURGICAL HISTORY

Have you ever had any operations or surgical procedures? ☐ **No** ☐ **Yes If Yes,** list below.

Date:	Operation / Procedure:	Date:	Operation / Procedure:
___/___/___		___/___/___	
___/___/___		___/___/___	
___/___/___		___/___/___	

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FAMILY HISTORY

Have any of your blood relatives had the following?

	Unknown	No	Yes	If Yes, explain who:
Cancer	☐	☐	☐	: _____
Diabetes	☐	☐	☐	: _____
Heart disease	☐	☐	☐	: _____
Lung disease	☐	☐	☐	: _____
Kidney disease	☐	☐	☐	: _____
Neurological disease (migraines)	☐	☐	☐	: _____
Skin disease	☐	☐	☐	: _____
Blood disorder	☐	☐	☐	: _____
Gastrointestinal problems (belly, bowels, etc.)	☐	☐	☐	: _____
Rheumatological problems	☐	☐	☐	: _____

SOCIAL HISTORY

Ethnicity: _____

Relationship status: ☐ Single ☐ Married ☐ Partnered ☐ Separated

Smoking (Check all that apply):

☐ Never smoker ☐ Unknown if ever smoked ☐ Smoker, current status unknown
☐ Former smoker ☐ Current smoker, some days ☐ Current smoker, everyday
☐ Heavy tobacco smoker (More than 10 per day) ☐ Light tobacco smoker (Less than 10 per day)

Alcohol: Do you drink alcohol? ☐ No ☐ Yes

If Yes, how many drinks per week: _____ For how many years: _____

Drugs: Do you use, or have you ever used, recreational drugs? ☐ No ☐ Yes
Do you use, or have you ever used, intravenous drugs? ☐ No ☐ Yes

If Yes to any of the above, explain: _____

Work: Are you currently working? ☐ No ☐ Yes

If Yes, what is your occupation: _____ ☐ Full time ☐ Part time

If No: ☐ Retired ☐ Unemployed

If you are not working, is it because of medical problem(s)? ☐ No ☐ Yes

Are you disabled or receiving disability benefits? ☐ No ☐ Yes

If Yes, year started: _____ Date last able to work: ____ / ____ / ____

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REVIEW OF SYSTEMS — Have you had any of the following symptoms *within the past 12 months*? Please check either "**No**" or "**Yes**" for each symptom below.

	No	Yes
Constitutional		
Are you in good health?	☐	☐
Unexplained weight loss / gain	☐	☐
Hematology / Lymphatic		
Bruising easily	☐	☐
Anemia / abnormal bleeding	☐	☐
Painful or enlarged glands	☐	☐
Genitourinary		
Problems with urination	☐	☐
Gastrointestinal		
Abdominal (belly) pain	☐	☐
Change in bowel habits	☐	☐
Stomach ulcers	☐	☐
Hepatitis / liver disease	☐	☐
Kidney disease	☐	☐
Thyroid disease	☐	☐
Endocrine		
Increased thirst or sweating	☐	☐

	No	Yes
Cardiovascular		
Do you have swelling in your ankles?	☐	☐
Do you have palpitations?	☐	☐
Psychiatric		
History of depression or other psychiatric illness	☐	☐
Neurologic		
Headaches / blurred vision	☐	☐
Seizures / epilepsy / stroke	☐	☐
Skin		
Rashes or ulcers	☐	☐
Ears, Nose, Throat and Mouth		
Trouble swallowing	☐	☐
Do you wear hearing aids?	☐	☐
Gynecological ☐ N/A		
Are you pregnant?	☐	☐
Date of last menstrual period: ____ / ____ / ____		
Are you breastfeeding?	☐	☐

Patient Certification: I have answered these questions to the best of my ability. I understand that this information will be used to guide my care.

X _____ _____ **OR**
Patient's Signature — Print Name

X _____ _____ **and** _____
Signature of Person authorized to sign for patient — Print Name — Relationship to patient

Date: ___ / ___ / ___ **Time:** ___ : ___ ○ a.m. ○ p.m.

THIS SECTION TO BE COMPLETED BY MEDICAL ASSISTANT

Height: _____ in **Weight:** _____ lbs **BP:** _____ / _____ **Pulse:** _____

X _____ _____ ____ / ____ / ____ ____ ____ ____ ____
Signature of Medical Assistant — Print Name — Date — Time (24 hour)

Clinician Review: I have reviewed the above information with the patient.

INTERPRETER (if applicable) – Name or ID #: _____

X _____ _____ ____ / ____ / ____ ____ ____ ____ ____
Circle: M.D. / N.P. / P.A. - Signature — Print Name — Date — Time (24 hour)

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