**PATIENT QUESTIONNAIRE** **Ben Pradhan, MD**

**Name:**_____Age: _____Weight: _____Height:_____

**What is your reason for visit?**:_____

How did it begin (suddenly, gradual, accident)?_____

How long has this been going on?_____

Is it constant or occasional?_____

Is it getting worse, same, or better?_____

Rate the pain/discomfort from 1 to 10 (10 being the worst):_____

Does the pain/discomfort go into the arms or legs? Which one?_____

If pain/discomfort goes into arms or legs, is there numbness, tingling, or weakness?_____

_____

What makes it worse (lifting, bending, sitting, walking)?_____

What makes it better (resting, sitting, standing, nothing)?_____

Have you:

Lost control of bowel or bladder because of this?_____

Had prior x-rays, CT, MRI, bone scans for this?_____

Seen another doctor for this (what type of doctor)?_____

Had previous Physical Therapy for this?_____

Had previous spine surgery for this problem (what type)?_____

Used any assistive devices (cane, walker, brace)?_____

Taken any medication for this (what type)?_____

Had any spinal injections (epidural, cortisone) for this?_____

When?_____Did they help?_____

**What other medical problems do you have?** (eg Asthma, Diabetes, High Blood Pressure, etc)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

**Allergies to any medications?** Check box if No Known Drug Allergies → [ ]

| Medication: | Reaction: | Medication: | Reaction: |
|---|---|---|---|
| | | | |
| | | | |

**Family medical problems?** (eg Asthma, Heart disease, Diabetes, Cancer, etc)

Father: _____

Mother: _____

Sibling: _____

Do you **smoke?** [ ] current everyday smoker [ ] current some days smoker [ ] former smoker [ ] never smoked

Use **drugs?** [ ] never [ ] in the past [ ] currently [ ] type of drug: _____

Drink **alcohol?** [ ] never [ ] rarely [ ] socially [ ] frequently ( more than twice per week) [ ] alcoholic

**What medications are you currently taking?** (You may attach a list)

_____ _____ _____
_____ _____ _____
_____ _____ _____

**What surgeries have you had in the past?** Approximate date of surgery:

_____ _____
_____ _____
_____ _____

**Please mark any of the following medical issues that you are having or may have had in the past:**

| | | | |
|---|---|---|---|
| ☐ Chronic fever, chills | ☐ Eye problems | ☐ GI/ stomach problems | ☐ Hormonal problems |
| ☐ Major weight gain or loss | ☐ Swollen neck glands | ☐ Muscle / Joint problems | ☐ Blood/ bleeding problems |
| ☐ Skin problems | ☐ Lung problems | ☐ Neurologic problems, headaches | ☐ Cancer of_____ |
| ☐ Ear problems | ☐ Heart problems | ☐ Psychiatric _____ | ☐ Other_____ |

**Your primary medical (family) doctor?** Name: _____ Tel #_____
Address: _____
_____

**Did a doctor refer you here, and if so who?** Name: _____ Tel # _____
Address: _____
_____

---

**OFFICE USE ONLY BELOW THIS LINE:** Vital Signs:

**Phy Exam: (pertinent positives)**

_____

**IMAGING:** [ ] MRI: [ ] L-Spine [ ] T-Spine [ ] C-Spine [ ] w/ contrast
[ ] CT: [ ] w/ contrast (myelogram)
Other:_____

**INJECTIONS**:_____
[ ] Sheng [ ] Tsuruda [ ] Furdik/Kennedy [ ] Other: _____

**CONSULTATION**: [ ] pre-op med clearance [ ] cardiac clearance
_____

**SURGERY**: Time _____ [Always 1 microscope and at least 1 C-arm (2 for kyphos)]
Levels:_____ [ ] Bilateral [ ] Left [ ] Right
[ ] Anterior [ ] Posterior [ ] Anterior and Posterior
[ ] Decompression/Diskectomy [ ] Decomp & Stabilization [ ] Kyphoplasty
[ ] Reg OR table [ ] Reg OR table reversed [ ] Reg OR tab + C-spine Mayfield tongs [ ] Jackson tab [ ] Jackson + Wilson

INSTRUMENTATION:
_____
_____

OTHER:_____
_____

[ ] Meds [ ] PT [ ] DME

RISSER ORTHOPAEDIC GROUP

**Patient Name: _____ Room #_____**

**Height_____ Weight _____ B/P _____ Temp _____**

**PCP: _____ Referred by: _____**

---

**Dr:** Laster Northrop Norquist Pradhan Mostofi Criswell Moradian Myers

Work Comp Medicare PPO Orthocenter HCP Cash Other:_____

---

**Please circle any of the following symptoms you have been recently experiencing:**

| | | | | |
|---|---|---|---|---|
| **General:** | Chills | Fever | Weight Gain | Weight Loss |
| **Skin:** | New Lesions | Rash | | |
| **HEENT:** | Blurred Vision | Double Vision | Hearing Loss | |
| **Respiratory:** | Cough | Wheezing | | |
| **Cardiovascular:** | Chest Pain | Shortness of Breath | Abnormal Blood Pressure | |
| **Gastrointestinal:** | Abdominal Pain | Nausea | | |
| **Musculoskeletal:** | Back Pain | Joint Pain | Joint Stiffness | Decreased Range Of Motion |
| | Joint Swelling | Muscle Pain | Muscle Weakness | Swelling of Extremities |
| **Neurological:** | Fainting | Headaches | Incontinence Stool | Incontinence Urine |
| | Un-coordination | Numbness | Stroke | Trouble Walking |
| | Unsteadiness | Weakness | Weakness in Limbs | |
| **Psychiatric:** | Anxiety | Depression | | |
| **Endocrine:** | Cold Intolerance | Excessive Sweating | Heat Intolerance | |
| **Hematology:** | Abnormal Bleeding | Blood Clots | Easy Bruising | |

☐ **None of the Above Apply**

---

**STOP –** DO NOT WRITE BELOW THIS LINE – OFFICE USE ONLY

---

Last Office Visit:_____ Surgery Date: _____

Reason for visit: _____

_____

_____

_____

_____