TO EXPEDITE SCHEDULING, ANSWER EVERY QUESTION

GRACE
SPINE CENTER

Sergiy Nesterenko, M.D.
Orthopedic Spine Surgery

4515 Marsha Sharp Fwy
Lubbock, TX 79407

Name:_____ Date of birth: _____ Age: _____

Referred by: _____

Name and **address** of primary care provider: _____

Main complaint: _____

Additional complaints: _____

Rate your Pain: 0 (no pain) - 10 (worst pain you can imagine):_____

What percent is in your: arm vs. neck: ____% / ____% (out of 100%)

leg vs. low back: ____% / ____% (out of 100%)

What makes it worse? _____

What makes it better? _____

Which **part of the day** is your pain worst? _____

How far can you walk?_____

Do you use assistive devices for walking? (cane, walker, shopping cart, scooter) _____

How long have you had the symptoms? _____

Was there any trauma before the symptoms started? _____

Were you involved in a motor vehicle accident?_____

Did you have a work-related injury? _____ If yes, date of injury: _____

Is there any active litigation?_____

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Are you right- or left-handed? _____

Do you have difficulties handling small objects (buttoning a shirt, tossing coins)? _____

Any changes in handwriting? _____

Do you have any difficulties with balance? _____

Have you experienced any falls? _____

Do you have any problems with bladder or bowel function? (describe, if yes) _____
_____

Previous treatments (include how much relief they provided):

Physical therapy: yes/no; **when; for how long;** effect: _____

Chiropractic treatments: yes/no; effect _____

What medications have you tried for your spine problem (names and doses)? Have they helped?:
_____
_____

Have you tried Neurontin (Gabapentin) or Lyrica? _____

Injections: (**bring documentation to the appointment**) dates, type of injection, name of hospital, name of physician, did it help? _____
_____
_____

Prior neck or back surgeries: (**bring documentation to the appointment**) dates, name of operation, name of hospital, name of physician, did it help? _____
_____
_____

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List **all health problems** that you have: _____

heart problems? _____ blood clots or excessive bleeding? _____

diabetes? _____ cancer? _____

chronic infections (hepatitis, HIV)? _____ unintentional weight loss? _____

fever or chills? _____ night sweats? _____

Is your strength today the same as several days ago? _____

History of osteoporosis? _____ bone fractures/breaks? _____

Have you had a bone density test? When? _____

Do you use any tobacco products? (if yes, what kind and how much) _____

history of IV drug use? _____ alcohol use? (how many drinks a week) _____

Past surgical history (not spine related):_____

Do you have: Pacemaker? Implanted defibrillator? Spinal cord stimulator?

Medications:

Blood thinners (including Aspirin and anti-inflammatories)? _____

Prescribing doctor: _____

Steroids? _____ Other medications (attach a list): _____

Allergies: _____ _____

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Social history:

married single divorced widowed

Children:_____

Present occupation: _____ If retired, what did you use to do? _____

If on disability, for what reason? _____

_____

Previous imaging (xrays, MRI, CT, myelograms, bone scans) – bring both images and reports

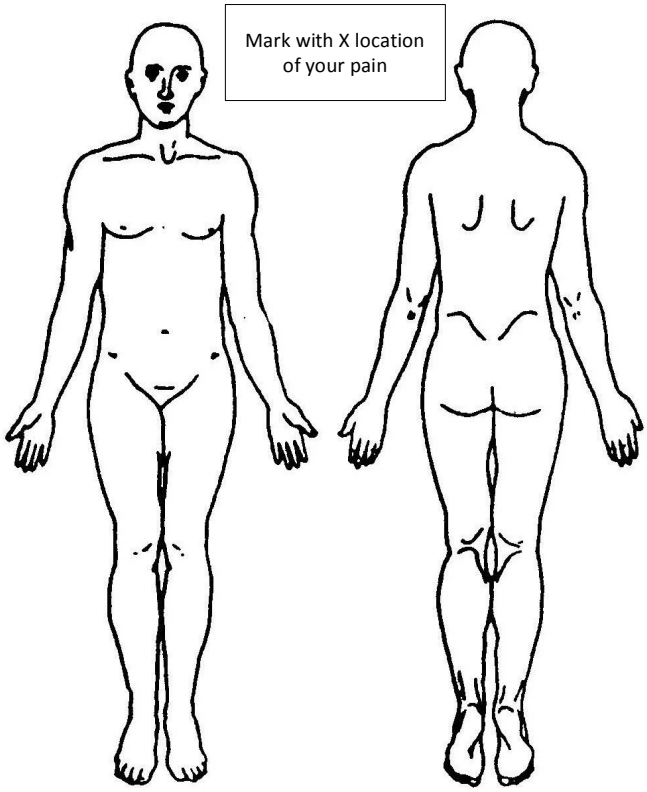
Name of the study, date: _____

Any additional studies (nerve conduction study, electromyography, blood work):

Name of the study, date: _____

Mark true or false to the following questions:

	True	False
I have low energy most days		
Most of time I do not get restful sleep		
I spend >12 hours a day resting and/or sleeping		
My pain causes me a great deal of suffering		
I have pain in two or more parts of my body		



I have answered the questions to the best of my ability.

Signature_____ Date_____