UNIVERSITY *of* MISSOURI

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DIVISION OF NEUROSURGERY

NEUROSURGERY PATIENT QUESTIONNAIRE – DR. MOLLMAN'S CLINIC

ABOUT YOU (Please print clearly)

Name_____ Birth Date _____ Age_____

Sex: Male__Female__ Referring MD _____

Mailing Address:_____ Address _____

_____ _____

Home phone number_____ MD Phone number_____

Work number_____ Any other MD you request we send information to?

Employer_____ -if so name, address and phone _____

Employer address_____ _____

PATIENT HEALTH HISTORY

CHIEF COMPLAINT: What specifically brings you to see the physician today? Please describe your symptoms or the questions you want answered.

_____

_____

_____

_____

HISTORY OF PRESENT ILLNESS:

1. Describe present symptoms: Location, severity, onset and duration.

_____

_____

If you have pain or numbness or other sensory changes, please mark the areas on the next page and answer the following questions that apply to you:

O Morning O Later in the day O During the night O Always the same

What activities worsen your symptoms?

O Arm overhead O Lifting O Riding and/or driving a car O Sneezing O Straining bowels

O Climbing stairs O Sitting O Movement of the neck/back O Standing O Walking

O Coughing O Other_____

Have changes occurred in your bladder, bowel, or sexual function? O YES O NO

If YES, please describe: _____

2. Describe how it happened or what you think caused it:

_____

_____

3. When did the symptoms begin? Month and date._____

4. If injury / accident related, date of injury / accident: _____

5. Is this injury related to work? O YES O NO O UNCERTAIN

6. Have you filed a Workers' Compensation claim? O YES O NO

7. Is this injury related to an auto accident? O YES O NO

8. Is a lawsuit in progress or being planned? O YES O NO

9. Please list tests you have already had:

O MRI O CT O Myelogram O Discogram O Regular Spine X-rays

O Bone Scan O EMG O Angiogram O Other

10. Please list all other physicians and chiropractors who you have seen for this problem and treatments that have been performed:

DATE PHYSICIAN TREATMENTS LOCATION

_____

_____

_____

11. Have you been in physical therapy? O YES O NO

DATE FREQUENCY DATE ENDS LOCATION

_____

_____

12. What (other) treatments have you already had (injections, acupuncture, previous spinal surgery)?

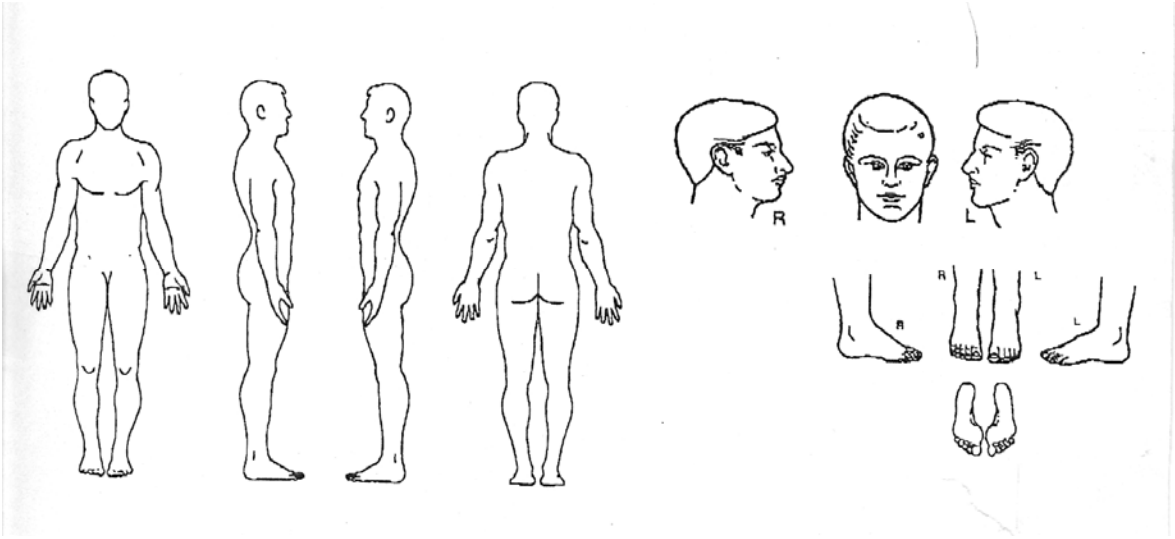
_____

_____

SENSATION DRAWING

Where is your pain now? Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas.

Face pain	Neck pain	Arm pain	Back pain	Leg pain	Total Score=
_____%	_____%	_____%	_____%	_____%	= 100%
SYMPTOM=	Ache	Numbness	Pins / Needles	Burning	Radiating Pain
SYMBOL=	^^^^^^^^	000000000	==========	xxxxxxx	////////////////////



How bad is your pain?

On a scale of 0 to 10 (0 = no pain, 5 = moderate, 10 = worst pain)

At its very worst 0 1 2 3 4 5 6 7 8 9 10

Now 0 1 2 3 4 5 6 7 8 9 10

Overall, is your pain generally: O Improving O Same O WORSENING?

PAST MEDICAL HISTORY. List significant illnesses or hospital stays without surgery.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Are you a diabetic? O YES O NO

SURGERY AND HOSPITALIZATION HISTORY. List ALL previous surgeries and hospitalization, include dates and physicians names.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Are you pregnant? O YES O NO How many pregnancies? ____ How many births? _____

FAMILY HISTORY:

		Current Age or Age at Death	Health Problems or Cause of Death
FATHER:	O Alive O Deceased		_____
MOTHER:	O Alive O Deceased	_____	_____

	Number	Ages	Serious Illnesses	Number Deceased / Cause
Sisters:	_____	_____	_____	_____
Brothers:	_____	_____	_____	_____
Daughters:	_____	_____	_____	_____
Sons:	_____	_____	_____	_____
Spouse:	_____	_____	_____	_____

Do you know of any blood relative who had had the following illnesses: If yes, check all that apply and provide relationship to patient?

O Aneurysm_____ O Chiari Malformation_____ O Lung Disease_____
O Brain Hemorrhage_____ O Diabetes_____ O Seizures_____
O Brain Tumor_____ O Heart Disease_____ O Stroke_____
O Cancer_____ O Spinal Disease_____

NEUROSURGERY SERVICES:

CURRENT MEDICATIONS. Please complete the medication list below with the medications you are currently taking. If you have difficulty completing this form, please bring your medication with you to your appointment. Include name, dose, and frequency.

Medication:	Dose	How often you take it?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES. Include medications, foods, tapes, latex. Include what adverse reaction you experience.

_____
_____
_____

Do you wear a prosthesis, pacemaker, or metal implant? O YES O NO
If yes, please specify. _____
Are you claustrophobic (having fears or anxiety in a confined environment, i.e. MRI)? O YES O NO

SOCIAL HISTORY AND HABITS:

1. O Married. O Divorced. O Single. O Widow / Widower. O Significant Other.
2. Who lives with you?

_____

3. If you have surgery, who can help you when you go home from the hospital?

_____

4. Do you smoke? O YES O NO If so, how much? _____ ___pack per _____
   Did you ever quit? O YES O NO. IF so, when did you quit? _____
   Are you interested in assistance with quitting? O Medication O Self help
5. Are you exposed to second hand smoke? O YES O NO
6. Do you use alcohol? O YES O NO If so, how much? _____ When did you quit? _____
7. Do you use and "street" drugs? O YES O NO If so, how frequently? Did you ever use any? _____
8. Are you retried? O YES O NO
9. Are you employed? O YES O NO If so, where? O Full Time O Part time O Disabled since___
   Present and / or former occupation_____
   Describe the type of work you do (i.e. lifting, standing, sitting).

_____
_____

   How many years have you done this job?

_____

   Have you lost work due to this current injury? _____ Last date worked_____

NEUROSURGERY SERVICE REVIEW OF SYSTEMS:
Please check those times that pertain to you during your lifetime.

ALLERGIES
- ☐ Asthma
- ☐ Hay fever
- ☐ Other _____

CARDIOVASCULAR
- ☐ Heart attack
- ☐ Heart surgery
- ☐ Stents
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Difficulty breathing at night
- ☐ Heart Murmur
- ☐ Irregular heart beat
- ☐ Pacemaker
- ☐ Poor circulation
- ☐ Swollen legs or feet
- ☐ Varicose veins
- ☐ Other_____

EARS/NOSE/THROAT
- ☐ Bleeding gums
- ☐ Difficulty swallowing
- ☐ Earache
- ☐ Hoarseness
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Eyeglasses/contacts
- ☐ Disease/injury
- ☐ Glaucoma
- ☐ Hearing Loss
  - o Right o Left

ENDOCRINE
- ☐ Diabetes
- ☐ Excessive hunger/ thirst
- ☐ Intolerance to warm room
- ☐ Loss of libido
- ☐ Multiple broken bones
- ☐ Rapid weight gain
- ☐ Rapid weight loss
- ☐ Spontaneous nipple discharge
- ☐ Thyroid problems
- ☐ Other_____

Patient Signature:

_____

EYES
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Double vision
- ☐ Eye infections
- ☐ Vision flashes or halos
- ☐ Other_____

GENERAL
- ☐ Chills/sweat/fever
- ☐ Difficulty sleeping
- ☐ Headache
- ☐ Recent fatigue
- ☐ Recent weight gain
- ☐ Recent weight loss

GASTROINTESTINAL
- ☐ Black stools
- ☐ Blood in stools
- ☐ Chronic diarrhea
- ☐ Heartburn/ acid reflux
- ☐ Hepatitis A,B,C (circle one)
- ☐ Increasing constipation
- ☐ Liver disease
- ☐ Nausea
- ☐ Vomiting
- ☐ Other_____

GENITOURINARY
- ☐ Difficulty to initiate/retention
- ☐ Discharge from penis/vagina
- ☐ Kidney Stones
- ☐ Incontinence (loss of urine)
- ☐ Prostate problem
- ☐ Urgency
- ☐ Urinary Tract infection
- ☐ Painful urination
- ☐ Other_____

HEMOTOLOGIC
- ☐ Easy skin bruising
- ☐ Marked fatigue
- ☐ Prolonged bleeding
- ☐ Tender glands/lymph nodes
- ☐ Other_____

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Muscle tenderness
- ☐ Muscle spasms
- ☐ Muscle weakness
- ☐ Joint swelling in
  - o Hands o Hips
  - o Wrists o Knees

MOOD
- ☐ Anxiety
- ☐ Depression
- ☐ Panic attacks
- ☐ Restlessness
- ☐ Other_____

RESPIRATORY
- ☐ Chronic cough
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Coughing of blood
- ☐ Night sweats
- ☐ Short of Breath
- ☐ Tuberculosis (TB)
- ☐ Asthma/Wheezing
- ☐ Other_____

NEUROLOGICAL
- ☐ Fainting
- ☐ Headaches
- ☐ Numbness of arms or legs
- ☐ Problem with memory
- ☐ Confusion
- ☐ Stroke
- ☐ Seizures
- ☐ Head injury
- ☐ Tingling of hands/arms/legs
- ☐ Other_____

SKIN
- ☐ Chronic skin itching
- ☐ Color changes of hands or feet in the cold
- ☐ Poor scarring/non-healing ulcer
- ☐ Skin rashes or hives
- ☐ Unusual moles
- ☐ Other_____

LAST VISIT WITH
- ☐ Dentist_____
- ☐ Ophthalmologist_____
- ☐ Primary Care Doctor_____