CHRISTINE PFISTERER, DO

INTERVENTIONAL SPINE & REHAB MEDICINE

NAME: _____ DATE OF VISIT: _____

HEIGHT: _____ WEIGHT: _____ AGE: _____

REASON FOR VISIT: _____ RIGHT: _____ LEFT: _____

Please Circle All That Apply:

QUALITY OF PAIN: SHARP DULL/ACHY BURNING NUMBNESS/TINGLING

SEVERITY OF PAIN: 1 2 3 4 5 6 7 8 9 10

TIME OF DAY THAT SYMPTOMS OCCUR: DAY NIGHT ALL TIMES OF DAY

DOES PAIN WAKE YOU FROM SLEEP: YES NO

HOW LONG HAVE SYMPTOMS BEEN PRESENT: _____

IF INJURY RELATED, DATE OF INJURY: _____

IS THIS WORK RELATED? YES NO

IS THIS MOTOR VEHICLE ACCIDENT RELATED? YES NO

WHICH ACTIVITIES INCREASE YOUR SYMPTOMS? (circle all that apply)

Walking Standing Bending Lifting

Sitting Stairs Pushing Pulling

WHICH ACTIVITIES IMPROVE SYMPTOMS? _____

HAVE YOU BEEN SEEN BY ANOTHER PHYSICIAN FOR THIS PROBLEM? YES NO

IF SO, BY WHOM: _____

HAVE YOU HAD ANY TESTING DONE RELATED TO THIS PROBLEM? YES NO

IF SO PLEASE CIRCLE: X-RAY MRI CT SCAN OTHER: _____

WHERE WERE THESE STUDIES PERFORMED: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

PHARMACY: _____ ADDRESS: _____ PHONE #: _____

FOR OFFICE USE ONLY:

TEMP: _____ HR: _____ O2: _____

MEDICAL HISTORY:

PLEASE CIRCLE ALL THAT APPLY:

HEART DISEASE	YES	NO	HEART ATTACK	YES	NO
HEART MURMUR	YES	NO	CARDIAC STENTS	YES	NO
HYPERTENSION	YES	NO	ANEMIA	YES	NO
STROKE/TIA	YES	NO	SEIZURES	YES	NO
MIGRAINES	YES	NO	BLEEDING DISORDER	YES	NO
CANCER	YES	NO TYPE:_____	BLOOD CLOTS	YES	NO
PNEUMONIA	YES	NO	UTI	YES	NO
HEPATITIS	YES	NO	HIV/AIDS	YES	NO
DIABETES (I OR II)	YES	NO	NON HEALING ULCERS	YES	NO

FOR WOMEN:

MENSTRUAL PROBLEMS? YES NO

DO YOU HAVE ANY OTHER HEALTH CONDITIONS NOT LISTED ABOVE? IF SO, PLEASE LIST:

HAVE YOU HAD ANY PREVIOUS SURGERIES? IF SO, PLEASE LIST:

DRUG ALLERGIES: YES NO IF SO, PLEASE LIST: _____

DO YOU TAKE DAILY MEDICATIONS? YES NO IF SO PLEASE LIST BELOW:

WHAT MEDICATIONS HAVE YOU TRIED AND FAILED FOR THIS CONDITION?:

DO YOU SMOKE? CURRENT Y N PAST Y N

DO YOU DRINK ALCOHOL? YES NO

ANY OTHER DRUG USE? YES NO

MARITAL STATUS: S M D W

PLEASE CIRCLE ALL THAT APPLY:

HAVE YOU RECENTLY EXPERIENCED ANY OF THE FOLLOWING:

WEIGT GAIN/LOSS	YES	NO	NAUSEA	YES	NO
NIGHT SWEATS	YES	NO	VOMITING	YES	NO
FEVER OR CHILLS	YES	NO	DIARHEA	YES	NO
LOSS OF TASTE OR SMELL	YES	NO	BOWEL/BLADDER		
DIFFICULTY WALKING	YES	NO	ISSUES	YES	NO
HEADACHES	YES	NO	MEMORY LOSS	YES	NO

CHANGES IN VISION	YES	NO
RINGING IN EARS	YES	NO
NOSE BLEEDS	YES	NO
SHORTNESS OF BREATH	YES	NO
CHEST PAIN	YES	NO
PALPITATIONS	YES	NO

FAMILY HISTORY:

CANCER	YES	NO	RELATION:_____	TYPE OF CANCER:_____
DIABETES	YES	NO	RELATION:_____	
HEART DISEASE	YES	NO	RELATION:_____	
HEART ATTACK	YES	NO	RELATION:_____	
STROKE	YES	NO	RELATION:_____	
BLOOD CLOT	YES	NO	RELATION:_____	
OTHER	YES	NO	RELATION:_____	

PATIENT NAME:_____ SIGNATURE:_____

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Pain Scale Sheet

Patient Name: _____ Date: _____

Important: Please use symbols below to indicate the location and level of your pain during the last week, with "0" being no pain and "10" being intensely severe pain.

Pain Level Now	0	1	2	3	4	5	6	7	8	9	10
At its worst	0	1	2	3	4	5	6	7	8	9	10
At its best	0	1	2	3	4	5	6	7	8	9	10
At night	0	1	2	3	4	5	6	7	8	9	10

Pin/Needles	0	0	0	0
Numbness	=	=	=	=
Burning	X	X	X	X
Stabbing	/	/	/	/
Ache	^	^	^	^