TUALITY HEALTHCARE
An OHSU Partner

Date_____

Name: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____
PCP: _____ Who Referred: _____
If not referred, how did you choose this office? _____
Why are you seeing the doctor today? _____
_____
Please list major complaint(s) and describe their onset (i.e., lower back pain began in May 2012 after lifting):
_____

Are you having any? □ Numbness Where? _____
□ Weakness Where? _____
□ Loss of bowel or bladder control

What makes your symptoms better (please circle all that apply): Nothing, rest, changing position, standing, sitting, walking, running, kneeling, bending, twisting.

What worsens your symptoms (please circle all that apply): Nothing, rest, changing position, standing, sitting, walking, running, kneeling, bending, twisting.

Is this visit related to an injury? □ Yes □ No On the job? □ Yes □ No

If so, date of injury: _____ Date of last employment: _____
Do you have any open worker's compensation claims of any kind? □ Yes □ No
Do you have a lawsuit pending? □ Yes □ No
Please circle the description which applies to your intensity of pain: Stable, unchanged, gradually worsening, rapidly worsening, gradually improving, rapidly improving, completely resolved.

How long has the problem been present? _____ Day(s), _____ Week(s), _____ Month(s), _____ Year(s)

What started the pain/problem? _____

Quality of the pain (mark up to four): □ Sharp □ Shooting □ Crushing □ Tight Band
□ Numbing □ Pulsating □ Aching
□ Tingling □ Dull □ Throbbing

How severe is the pain at the location described above? □ No Pain □ Mild □ Moderate □ Severe

Is the pain (check all that apply)? □ Rare □ Infrequent □ Occasional □ Intermittent
□ Daily □ Continuous □ Weekly □ Monthly

What treatments have you tried for this problem?

□ Physical Therapy □ TENS units □ Narcotic Medications □ Muscle Relaxers
□ Massage □ Traction □ Anti-inflammatories □ Orthotics
□ Chiropractor □ Surgery □ Steroid injections □ Braces
□ Other: _____

Previous physicians seen for this problem?

Physician	Specialty	City	Treatment

Tuality Neurosurgery

333 SE 7th Ave. Suite 4350
Hillsboro, OR 97123
Phone: 503-844-8220 Fax: 503-844-8321

PAST MEDICAL HISTORY

DISEASES – Mark YES if you currently or have ever had any of the following - **do not leave any item blank**:

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	high blood pressure	☐	☐	stroke	☐	☐	asthma	☐	☐	IV drug use
☐	☐	convulsions/epilepsy	☐	☐	cancer	☐	☐	arthritis	☐	☐	sleep apnea
☐	☐	high cholesterol	☐	☐	stomach ulcers	☐	☐	diabetes type __	☐	☐	liver disease
☐	☐	thyroid problems	☐	☐	emphysema	☐	☐	bronchitis	☐	☐	kidney disease
☐	☐	hepatitis (yellow jaundice)	☐	☐	angina	☐	☐	colon problems	☐	☐	heart disease
☐	☐	bleeding tendency	☐	☐	tuberculosis	☐	☐	anemia	☐	☐	heart attack
☐	☐	multiple sclerosis	☐	☐	alcoholism	☐	☐	drug addiction	☐	☐	HIV/AIDS

Have you seen a heart doctor before? If so, who and when?_____

Additional disease(s) not listed: _____

ALLERGIES: ☐ NONE

☐ Penicillin ☐ Sulfa ☐ Demerol ☐ Metals ☐ Codeine ☐ Latex ☐ Adhesives

Additional allergies not listed: _____

MEDICINES - Current medications and **dosage/day**: ☐ NONE

Include any steroids or blood thinners (i.e. aspirin/coumadin) **Attach a separate sheet if necessary.**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PREVIOUS SURGERIES/FRACTURES with **APPROXIMATE DATE AND SPINAL OR CRANIAL LOCATION**:

☐ NONE ☐ _____Laminectomy: __/__/__ ☐ _____Laminotomy:__/__/__ ☐ _____Discectomy:__/__/__

☐ _____Fusion:__/__/__ ☐ _____Craniotomy:__/__/_

OTHER SURGERIES/FRACTURES **NOT LISTED** with **APPROXIMATE DATE**: _____

_____

_____

ACCIDENTS - List previous accidents **with date** and associated injuries: ☐ NONE

Automobile -__/__/__: _____

Slip/Fall - __/__/__: _____

Sports - __/__/__: _____

Other - __/__/__: _____

SOCIAL HISTORY

Current Employer: _____ Work Type: _____

Birth Place: _____ Education Level: _____

☐ Married ☐ Single ☐ Widowed ☐ Divorced/Separated ☐ Children: # of Boys _____ # of Girls _____

Do you use Tobacco? ☐ No ☐ Former, stopped? _____ ☐ Yes, Packs per day? _____ Years? _____

Do you use Alcohol? ☐ No ☐ Yes, If yes circle one of the following: Frequently Occasionally Rarely

List any Recreational Drugs you use: _____

Do you Exercise? ☐ Yes ☐ No What type of exercise: _____

FAMILY HISTORY

Have any of your immediate family members had (Mother, father, brother, sister):

YES	NO		Relationship to you:	YES	NO		Relationship to you:
☐	☐	high blood pressure	_____	☐	☐	stroke	_____
☐	☐	convulsions/epilepsy	_____	☐	☐	cancer	_____
☐	☐	bleeding tendency	_____	☐	☐	diabetes	_____
☐	☐	heart disease	_____	☐	☐	alcoholism	_____
☐	☐	Nervous/Mental Disorder	_____	☐	☐	tuberculosis	_____

PRINT NAME: _____ DATE: _____

Tuality Neurosurgery

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Review of Systems

Neurologic:

Yes	No		Yes	No	
☐	☐	Numbness	☐	☐	Fainting
☐	☐	Tingling	☐	☐	Lack of coordination
☐	☐	Weakness	☐	☐	Tremors
☐	☐	Muscle twitching	☐	☐	Problems walking
☐	☐	Muscle shrinkage	☐	☐	Loss of balance
☐	☐	Muscle cramps	☐	☐	Dizziness
☐	☐	Headache	☐	☐	Blackouts
☐	☐	Migraines	☐	☐	Other:

Constitutional:

Yes	No	
☐	☐	Loss of appetite
☐	☐	Fever
☐	☐	Chills
☐	☐	Weight loss
☐	☐	Other:

Musculoskeletal:

Yes	No	
☐	☐	Bone pain
☐	☐	Other:

EENT:

Yes	No		Yes	No	
☐	☐	Double vision	☐	☐	Hearing loss
☐	☐	Failing vision	☐	☐	Ear drainage
☐	☐	Blurry vision	☐	☐	Hoarseness
☐	☐	Wear glasses	☐	☐	Nose bleeds
☐	☐	Color Blindness	☐	☐	Other:

Hematologic:

Yes	No	
☐	☐	Excessive bleeding
☐	☐	Easy bruising
☐	☐	Other:

Cardiovascular:

Yes	No	
☐	☐	Chest pain
☐	☐	Palpitations
☐	☐	Other:

Gastrointestinal:

Yes	No		Yes	No	
☐	☐	Nausea	☐	☐	Abdominal pain
☐	☐	Vomiting	☐	☐	Other:
☐	☐	Heartburn indigestion			
☐	☐	Blood in stool			
☐	☐	Bowel incontinence			

Respiratory:

Yes	No	
☐	☐	Shortness of breath
☐	☐	Wheezing
☐	☐	Cough
☐	☐	Other:

Endocrine:

Yes	No	
☐	☐	Fatigue
☐	☐	Intolerance to heat
☐	☐	Intolerance to cold
☐	☐	Ankle swelling
☐	☐	Other:

Genitourinary:

Yes	No		Yes	No	
☐	☐	Urinary incontinence	☐	☐	Urinary urgency
☐	☐	Urinary hesitancy	☐	☐	Urinary frequency
☐	☐	Urinary dribbling	☐	☐	Other

Psychiatric:

Yes	No		Yes	No	
☐	☐	Depression	☐	☐	Confusion
☐	☐	Anxiety	☐	☐	Anger
☐	☐	Weeping	☐	☐	Explosive temper
☐	☐	Personality changes	☐	☐	Other:

I hereby attest that all the information of my Past Medical History, Review of Systems and this Pain Diagram are true and correct to the best of my knowledge.

Patient's Signature*: _____ Date: _____