

The Spine and Orthopedic Center
COMPREHENSIVE INTERVAL HISTORY FORM
Alan P. Moelleken, MD Spine Surgery

PATIENT _____ DOB _____ Today's Date _____
Last Name, First Name

Describe any symptom changes since your last visit:

Circle the number that best describes your current pain with "10" being the most severe.

Back/Leg 0 1 2 3 4 5 6 7 8 9 10
Neck/Arm 0 1 2 3 4 5 6 7 8 9 10

Circle what percent better or worse:
0 10 20 30 40 50 60 70 80 90 100%

Are you working? Yes No (circle)

Full duty _____ Modified duty _____

When did you last work? _____

How long/far can you:

Sit _____ Stand _____ Walk _____

Are you affected by lack of sleep? Yes No (circle)

If so how many hours do you sleep? _____

How does the lack of sleep affect you?

If you are taking medications, what and how much?

Are you having any complications or side effects from your medications? Yes No (circle) If yes, please explain:

Continue.....

If you are using topical creams or lotions please answer the questions in this box:
Which topical cream(s) or lotion(s) are you using - please list:

Does the topical cream or lotion help to decrease your pain level? Yes No (circle)

Does this help you to sleep better? Yes No (circle)

Does this allow you to take fewer oral medications (pills)? Yes No (circle)

Does this help your level of function (ability to do more things?) Yes No (circle)

Additional comments on how the cream helps you:

Do you have stomach pain? Yes No (circle)

Have you had any nausea or vomiting since your last visit? Yes No (circle) If yes, what is the cause? Please explain:

Have you had any recent weight loss, fever, chills, or night sweats? Yes No (circle)

Do you have any problems with your bowels/bladder? Yes No (circle) If yes please explain: _____

Are you receiving physical therapy or chiropractic treatment? Yes No (circle)

If so where: _____ How many days per week: _____

What physical therapy or chiropractic treatments are you receiving? _____

Have you had any acupuncture since your last visit? Yes No (circle)

Are you using any aids such as : corset, cane, walker, body jacket, collar? (circle)

Have you had any medical tests since your last visit such as x-rays, MRI, blood tests, etc? Yes No (circle)

What and Where? _____

Have you had any spinal injections since your last visit? Yes No (circle) If yes, are you: Better Worse Same

Any additional comments: _____

Mark these drawings using the symbols that best describe your pain:

Numbness =====

Aching ^ ^ ^ ^ ^ ^

Pins and needles o o o o o o o

Stabbing ///////////////

Burning x x x x x x

Cramping ●●●●●●●●

FRONT

BACK

