PROLIANCE ORTHOPAEDICS & SPORTS MEDICINE
BELLEVUE • ISSAQUAH • REDMOND

LOWER BACK PAIN INFORMATION

Last Name___________________________ **First Name** ________________________ **MI** _____ **Date** __________

Age_________ **Birthdate** _________________ **Gender** M F

Occupation: ____

What is your **Main Problem** ? (Check all that apply)
- Low Back Pain
- Buttock Pain
- Mid Back Pain
- Upper Back Pain
- Leg Pain
- Thigh Pain

If you have Leg Pain which is worse?
- I Don't have Leg Pain
- Both Legs hurt about Equally
- Both, Right Worse than Left
- Both, Left Worse than Right
- Right Leg Pain Only
- Left Leg Pain Only

How many weeks, days or months ago did this start? ______________________

What Caused This Problem?
- I Don't Know
- Car Accident
- A Fall
- Lifting
- Sports Injury
- Other:_____________________________________

Did it start **Gradually or Suddenly**?
- Gradually
- Suddenly

Have you seen any other Doctors For this? Yes No
If Yes write their names in order of #1 being the most recently seen.
1)______________________________
2)______________________________
3)______________________________
4)______________________________
5)______________________________

What Tests Have You Had Done For This?
- X-rays
- Blood Tests
- MRI
- CAT Scan
- Myelogram
- Bone Scan
- Discogram
- EMG
- Nerve Root Block

What Treatments Have You Had For This?
- Nothing
- Rest
- Anti-Inflammatories
- Pain Medicines
- Muscle Relaxers
- Massage
- Chiropractic
- Physical Therapy
- Back Exercises
- Epidural Steroid Injection
- Prednisone
- Other: ________________

Do you get any regular Exercise? Yes No If Yes What Kind?___________________________
How many times a week?______________________

Current Symptoms

Which of these **symptoms** do you have **now**?
- Back Pain
- Buttock Pain Rt. Lt.
- Leg Pain Rt. Lt.
- Numbness Where:____________________
- Tingling Where:____________________
- Leg Muscle Weakness
  Explain: ____________________
- Trouble Controlling Bowels or Bladder
- Pain with Coughing, Sneezing or Straining
- Pain that Wakes you from Sleep

Is Your **Back Pain or Leg Pain Worse**?
- Back Pain Worse than Leg Pain
- Leg Pain Worse Than Back Pain
- Back Pain about Equal to Leg Pain

Is Your Back Pain: Aching Burning Stabbing Sharp Dull Stiff Pins and Needles
Worse in the: Morning Evening Nighttime Mid Day

Is Your Leg Pain: Aching Burning Stabbing Sharp Dull Stiff Pins and Needles
Worse in the: Morning Evening Nighttime Mid Day

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What Makes Your Pain Worse?	What Makes Your Pain Better?
Sitting	Sitting
Standing	Standing
Walking	Walking
Lying Down	Lying Down
Exercise	Exercise
Lifting	Pain Medicine
Bending Forward	Anti-Inflammatories
Bending Backward	Massage
Working	

Do You Have Any of the Following **Symptoms** ?

Feeling Sick Weight Loss Fevers Shaking Chills Nausea
Severe Morning Stiffness Chronic Diarrhea

How Far can you Walk Comfortably?	**How Long Can You Stand Comfortably?**	**Sit Comfortably?**
A few Steps Only	Less Than 5 Minutes	Less Than 5 Minutes
Across The Street	Less Than 10 Minutes	Less Than 10 Minutes
Less Than 2 Blocks	Less Than 20 Minutes	Less Than 20 Minutes
Less Than A Mile	Less Than 1 Hour	Less Than 1 Hour
More Than A Mile	More Than 1 Hour	More Than 1 Hour

Are You Taking Any Medications For This Now?

Medication Name Pills Per Day

1) ______________________________
2) ______________________________
3) ______________________________
4) ______________________________

Recently are your symptoms?

Getting Worse
Staying About the Same
Getting Better

Previous Back Problems

Have You Had **Back Problems Before** This? Yes No If Yes How many years ago did it start? ______

Have You Had **Surgery on Your Back** Before? Yes No
If Yes Please List the Type of **Operation**, Approximate Year , and Doctor's Name

Operation	**Year**	**Doctor**
1)		
2)		
3)		
4)		

Social History

How Far Did You Get In **School**?
Didn't Graduate High School HS Grad
Some College College Grad
Professional or Advanced Degree
Are You **Married**? Yes No
How Many **Children**? 1 2 3 4 5 6
Are You **Working** ? Disabled Retired Working
Parenting Taking Time Off Unemployed

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Previous Medical Problems

Please Check Any Medical Problems You Have Had or Currently Have

Cardiac
- Hypertension
- Coronary Artery Disease
- Myocardial Infarction
- Congestive Heart Disease
- Atrial Fibrillation
- High Cholesterol

Respiratory
- COPD
- Asthma

Endocrine
- Diabetes
- Hypo- Thyroidism
- Hyper – Thyroidism

GI
- Irritable Bowel Syndrome
- Colon Cancer
- Diverticulitis
- GE Reflux
- Hepatitis
- Ulcer Disease

Urinary and Genital
- Enlarged Prostate
- Kidney Stone
- Urinary Tract Infection
- Prostate Cancer
- Bladder Cancer
- Renal Cancer
- Ovarian Cancer
- Uterine Cancer

Musculoskeletal
- Degenerative Arthritis Of:_____________
- Rheumatoid Arthritis
- Fibromyalgia
- Neck Pain
- Upper Back Pain

Skin
- Melanoma
- Other Skin Cancer
- Psoriasis

Neurologic
- Multiple Sclerosis
- Parkinson's
- Stroke
- Peripheral Neuropathy

Psychiatric/ Emotional
- Alcoholism
- Drug Use / Abuse
- Depression
- Anxiety Disorder
- Bipolar Disorder

Blood Disorders
- HIV
- Bleeding Disorder
- Anemia
- Leukemia
- Lymphoma

Ear/Nose/ Throat
- Lip/ Tongue or Throat Cancer
- Chronic Sinusitis
- Hearing Problems

Enter **Any Other Medical Problems Not Listed** Above Here:____

Please List Any **Allergies to Medicines?** ____

Please List **All Regular Medications?**____
____

Do You **Smoke**?   Yes   No   If Yes, How many packs per Day:_______

Alcohol: How Many **Drinks**, Glasses of Wine or Beers **per Day**:   **Never**   **<1**   **1**   **2**   **3**   **4**   **5**

Any **Medical Problems That Run in The Family**? ____

Review Of Systems

Circle Any Symptoms you have now.

Cardiac	Chest Pain	Leg Swelling	Irregular Heart Beats	Shortness of Breath Lying Down
Respiratory	Wheezing	Chronic Cough	Feeling Short of Breath Easily or at Rest	
GI	Heartburn	Blood In Stool	Black or Tarry Stools	Constipation
Urologic	Burning with Urination	Trouble With Urinary Stream	Blood in Urine	Frequent Urination
Musculoskeletal	Joint Pain or Swelling	Lower Back Pain	Severe Morning Stiffness	
Endocrine	Excessive Thirst	Weight Gain	Excessive Fatigue	Excessive Urination
Hematologic	Bleeding Problems	Easy Bruising		
Psychologic	Crying Frequently	Feeling Worthless	Lack of Libido	Trouble Sleeping
ENT	Eye Pain	Wear Corrective Lenses	Trouble Hearing	Sinus Congestion
Gynecologic	Pelvic Pain	Symptoms of pregnancy	Uterine Bleeding	Vaginal Discharge

Any other symptoms you would like to mention?____
____

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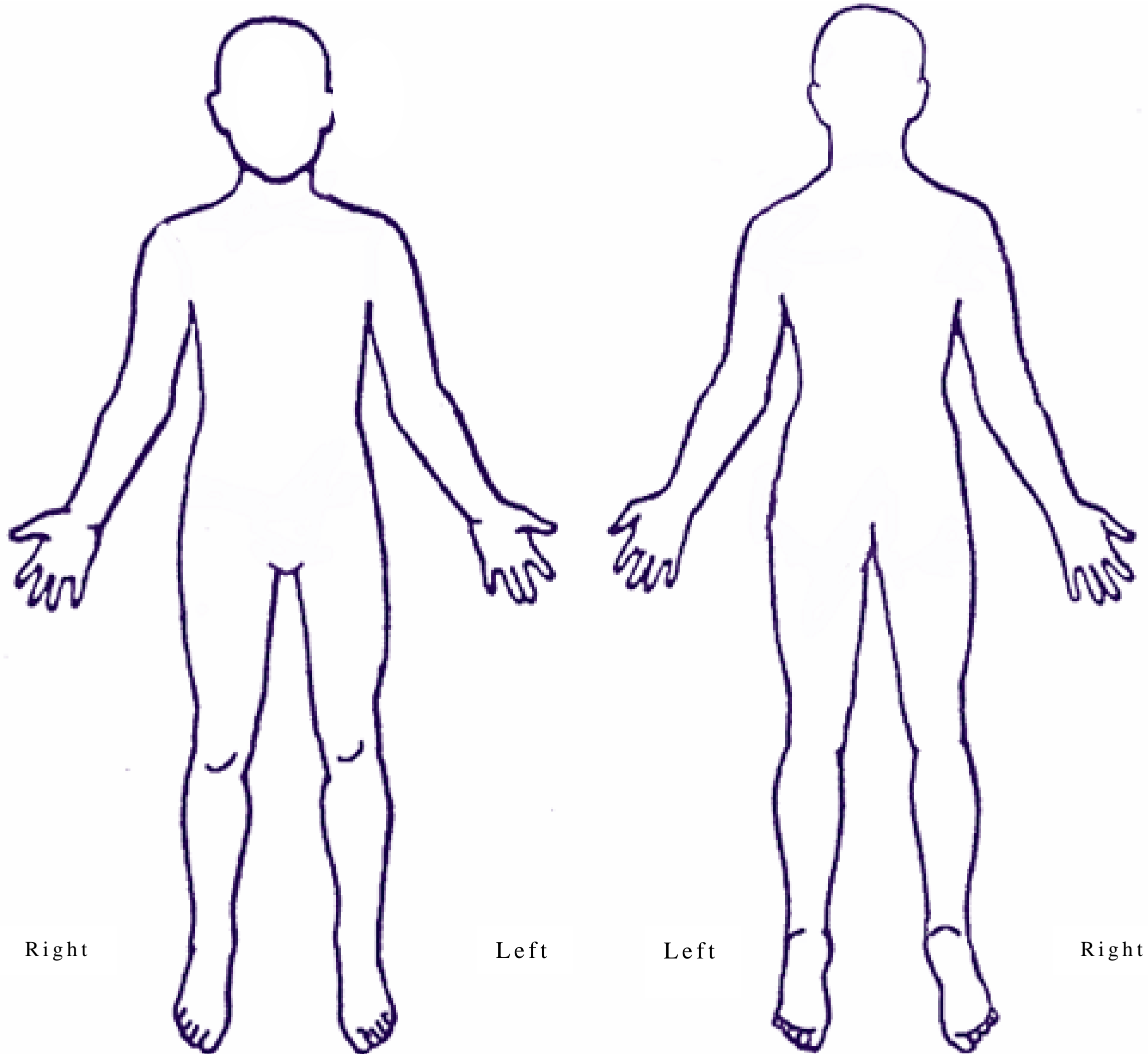
PATIENT PAIN DRAWING

Where is your pain now?
Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.
Mark the areas of radiation. Include all affected areas. To complete the picture please draw in your face.

Aching	Numbness	Pins and needles	Burning	Stabbing
▲▲▲	= = =	O O O	X X X	/ / /



How bad is your pain now?
Please mark and + on the body form where the pain is worst now
Please Mark on the line below how bad your pain in now

No Pain____Worst possible pain