Patient Intake Form
Maahir Haque MD

SPINE GROUP ORLANDO
AT CELEBRATION ORTHOPAEDICS

Patient Name _____ Age _____ DOB _____

Primary Care Physician _____ Date _____ How did you hear about Dr. Haque? _____

Chief Complaint: what is the main reason for your visit? If you have more than one, **please clarify what percentage of your problem falls under each category**.

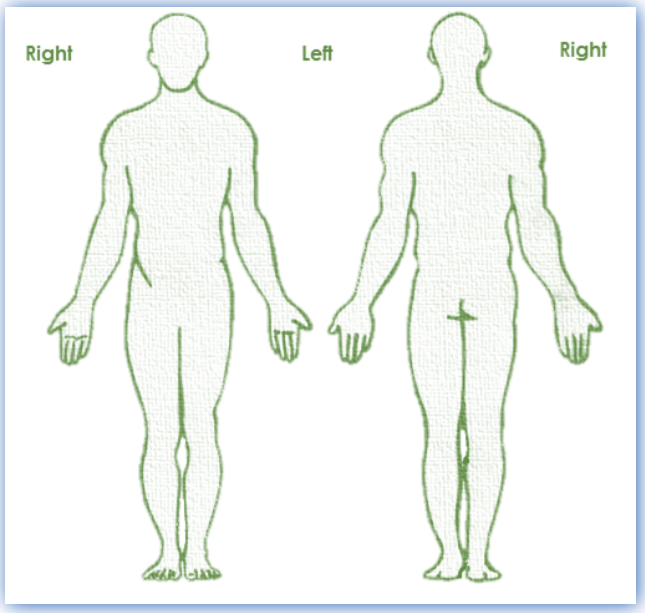
☐ Back Pain _____% ☐ Leg Pain _____% ☐ Neck Pain _____% ☐ Arm Pain _____%

How **severe** is your pain? 0=no pain → 10=worst pain imaginable

Today's Pain	0	1	2	3	4	5	6	7	8	9	10
Worst Pain	0	1	2	3	4	5	6	7	8	9	10
Best Pain	0	1	2	3	4	5	6	7	8	9	10

Pain Drawing: Please indicate **where** your pain is and **what type** of pain you have using the key to the left.

Key	
////	Stabbing
XXX	Burning
0000	Pins & Needles
===	Numbness
+++	Aching



Describe your symptoms (severity, location, timing, frequency):

_____

_____

_____

_____

_____

Patient Name _____ Date _____

What **increases** your pain?

☐ Sitting/Driving ☐ Leaning Forward ☐ Standing ☐ Walking ☐ Lying down

What **relieves** your pain?

☐ Sitting/Driving ☐ Leaning Forward ☐ Standing ☐ Walking ☐ Lying down

What caused your back issue? Was there **trauma**?

☐ Yes ☐ No ☐ Car accident ☐ Work accident/injury

If so, **describe when/where/how** you were hurt: _____

_____

How long have you had symptoms for?

☐ <6 weeks ☐ <3 months ☐ 3 months – 1 year ☐ >1 year

Progression: Are your symptoms **worsening/staying the same/improving**? _____

What is your **occupation**? _____

Are you still **working**?

☐ Yes/Full duty ☐ Light duty ☐ I am on temporary disability ☐ I am fully disabled because of _____ ☐ Retired

Have you experienced any of the following recently?

☐ Arm or Leg **Weakness**	☐ **Numbness**	☐ **Loss of bowel control**	☐ **Loss of bladder control**
☐ Unsteadiness on your feet	☐ Hand clumsiness, trouble with handwriting or buttoning a shirt	☐ Recent illness	☐ Recent **fevers**
☐ Night Pain	☐ Unintentional Weight Loss	☐ Chest Pain	☐ Shortness of Breath

Have you seen another physician about your back/neck problems? Who and when?

_____
_____
_____
_____

Patient Name _____ Date _____

What if any **treatment** have you received?

☐ Surgery
Date(s)
_____
_____
_____
_____
Procedure(s)
_____
_____
_____
_____

☐ Injections
Date(s)
_____
_____
_____
_____
Type(s)
_____
_____
_____
_____
_____

☐ Physical Therapy
Year
_____
Number of Weeks/Visits
_____

☐ Chiropractor

☐ Other:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

What **testing** has been done on your spine?

☐ MRI ☐ CT ☐ X-ray ☐ EMG ☐ Other: _____

Are you **allergic to latex**? What reaction did you have and when? _____
Have you had any bad reactions to anesthesia? _____
Do you take a **blood thinner**? Which and why do you take it? _____
Have you ever had a **DVT, PE, or blood clot**? When? Is there a family history? _____
_____
Do you have trouble with **easy bruising or excessive bleeding**? _____
Female patients: Are you or could you be **pregnant**? _____

Social History

Do you **smoke** or use tobacco? How much, for how long? _____ ____ packs/day for ___ years
Have you quit smoking? When, for how long? _____
Do you drink alcohol? _____ drinks every _____
Have you used illegal drugs? Which? Have you used prescription medicines other than as prescribed? _____
Do you **exercise**? How often? What do you do? _____

Patient Name _____ Date _____

Review of Systems – do you have any issues with the following body systems?

General
- ☐ Weight loss or gain
- ☐ Fatigue
- ☐ Fevers or Chills
- ☐ Weakness
- ☐ Trouble sleeping

Eyes
- ☐ Vision loss/changes
- ☐ Glasses or contact use
- ☐ Pain
- ☐ Blurry vision
- ☐ Flashing lights
- ☐ Specks
- ☐ Glaucoma

Ears/nose/mouth/throat
- ☐ *Ears*: Decreased hearing
- ☐ Ringing in ears
- ☐ Drainage
- ☐ *Nose*: Stuffiness
- ☐ Discharge
- ☐ Nosebleeds
- ☐ *Mouth/throat*: Bleeding
- ☐ Dentures
- ☐ Soreness
- ☐ Hoarseness
- ☐ Thrush

Respiratory
- ☐ Cough
- ☐ Sputum
- ☐ Coughing up blood
- ☐ Shortness of Breath
- ☐ Wheezing

Allergy/immunizations
- ☐ Hay fever
- ☐ Itching

Cardiology/vascular
- ☐ Chest pain, tightness, or discomfort
- ☐ Palpitations
- ☐ Shortness of breath with activities
- ☐ Difficulty breathing lying down
- ☐ Extremity swelling
- ☐ Awakening with shortness of breath

Psychiatric
- ☐ Nervousness
- ☐ Stress/anxiety
- ☐ Depression
- ☐ Memory loss

Gastrointestinal
- ☐ Swallowing difficulty
- ☐ Change in appetite
- ☐ Nausea
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Constipation
- ☐ Incontinence of stool

Genitourinary
- ☐ Infertility
- ☐ Burning or pain
- ☐ Blood in urine
- ☐ Incontinence

Musculoskeletal
- ☐ Muscle or joint pain
- ☐ Stiffness
- ☐ Back pain
- ☐ Redness of joints
- ☐ Swelling of joints
- ☐ Trauma

Neurological
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Tremor

Endocrine
- ☐ Sweating
- ☐ Frequent urination
- ☐ Thirst

Hematological/lymphatic
- ☐ Swollen glands
- ☐ Easy bruising
- ☐ Easy bleeding

Skin/Integumentary
- ☐ Rashes
- ☐ Lumps
- ☐ Itching
- ☐ Dryness
- ☐ Color changes
- ☐ Hair and nail changes

Please **Sign** below:

_____ **Date:** _____