

# Donald S. Corenman, MD

## New Patient Lumbar Spine History

Date:

/  /

*Please PRINT and fill out completely.*

Shade circles like this: ●

Med record #

Name \_\_\_\_\_ Age \_\_\_\_\_ yrs. D.O.B. \_\_\_\_\_

Height  ft  in Weight  lbs Sex  Male  Female Are you or could you be pregnant?  Yes  No

Your Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Who referred you to this office?  Dr. \_\_\_\_\_  PA/NP \_\_\_\_\_  
 If more than one, please note.  Friend/Word of Mouth \_\_\_\_\_  Physical Therapist \_\_\_\_\_  
 Family Member \_\_\_\_\_  Other \_\_\_\_\_

### HISTORY OF CARE

Who is your primary care physician? \_\_\_\_\_ Location: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Please list any other doctors, clinics, or hospitals you have seen for your current spinal problems:

Name	City	Date of First Visit	Currently Continuing?

### HISTORY OF CURRENT SPINAL PROBLEMS

List your chief complaints or main problems with the most severe first:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Describe all details of any accident, incident or the way these problems began:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### CURRENT SYMPTOMS

What time of day is your pain at its worst?  Morning  Afternoon  Evening  Night  Not Applicable

Does the pain wake you up at night?  Yes  No

In the past six months have you experienced:  Fever  Weight Loss \_\_\_\_\_ lbs  
 Chills  Night Sweats

How would you describe your pain?  Constant  Constant, but worse with activity  
 Intermittent  Intermittent, but worse with activity  
 (comes and goes)

Do you have full control of your bladder?  Yes  No

Do you have full control of your bowels?  Yes  No

# PATIENT PAIN DRAWING



17777

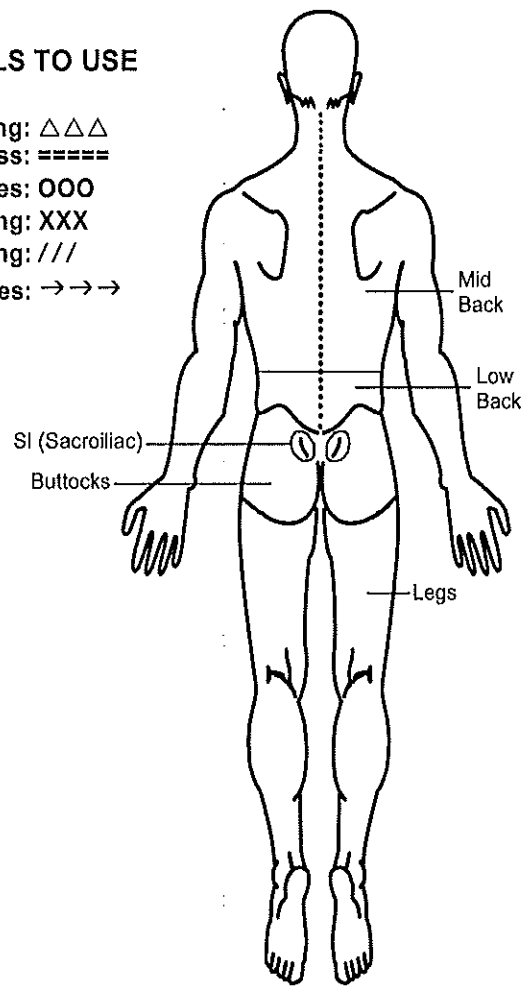
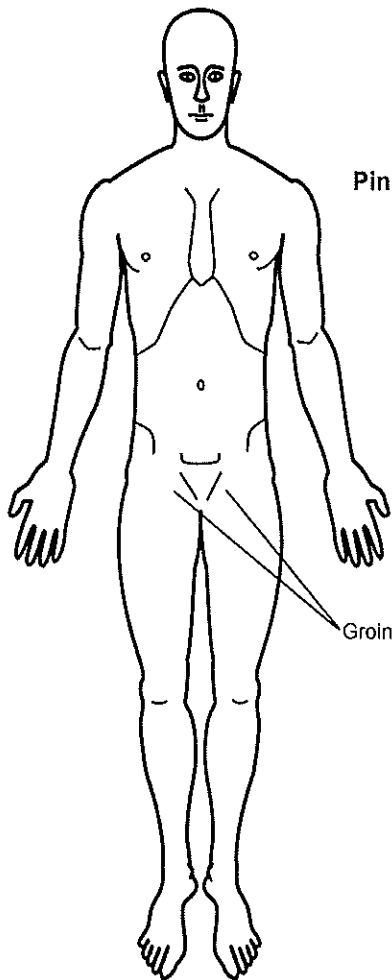
Please mark the areas on your body where you feel the pain and/or sensations described below, using the appropriate symbol as indicated. Mark the areas where your pain radiates, include all affected areas.

For Doctor Use Only			
	R	L	Both/axial
Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trap	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scap	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scp/Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LB/Sl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bl/Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M Bk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Groin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Complex  Positional

## SYMBOLS TO USE

- Aching:  $\triangle\triangle\triangle$
- Numbness: =====
- Pins & Needles: OOO
- Burning: XXX
- Stabbing: ///
- Radiates:  $\rightarrow\rightarrow\rightarrow$



Mark where any symptoms (pain, numbness, weakness, etc.) exist on average (most of the time) and at their worst.

		None											Unbearable										
Current mid back pain	Average	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Worst	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Current low back pain	Average	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Worst	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Current SI pain	Average	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Worst	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Current buttock	Average	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Worst	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Current groin pain	Average	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Worst	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Current leg pain	Average	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Worst	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

For Dr. Use Only	
MB <input type="checkbox"/>	Positional <input type="checkbox"/>
LB <input type="checkbox"/>	Positional <input type="checkbox"/>
SI <input type="checkbox"/>	Positional <input type="checkbox"/>
Buttock <input type="checkbox"/>	Positional <input type="checkbox"/>
Gr <input type="checkbox"/>	Positional <input type="checkbox"/>
Lg <input type="checkbox"/>	Positional <input type="checkbox"/>

# PAST MEDICAL HISTORY

Check if you currently are being treated for or have been diagnosed with:

	<i>When?</i>		<i>When?</i>
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Osteoporosis	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Kidney Disease/Problem	_____
<input type="checkbox"/> Liver Disease	_____	<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> Heart Disease or Attack	_____	<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Thyroid	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> High Lipids (cholesterol, etc.)	_____	<input type="checkbox"/> Psoriasis	_____
<input type="checkbox"/> Ulcer Disease	_____	<input type="checkbox"/> Polio	_____
<input type="checkbox"/> Gastritis	_____	<input type="checkbox"/> Rheumatic Fever	_____
<input type="checkbox"/> Reflux Disease (GERD)	_____	<input type="checkbox"/> Gout	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Herpes Simplex	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> <b>Other</b> _____	_____
<input type="checkbox"/> Bipolar Disease	_____		
<input type="checkbox"/> Other Psychiatric _____	_____		

Have you ever had a history of blood clots or pulmonary embolus?     Yes     No

## SURGERIES

Please list all **spine** surgeries you have had in the past:

<i>Type of Surgery</i>	<i>Date</i>	<i>Surgeon</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all **other** surgeries you have had in the past:

<i>Type of Surgery</i>	<i>Date</i>	<i>Surgeon</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## MEDICATIONS

Please list ALL medications you are **currently** taking, including prescription and over the counter:

<i>Medication</i>	<i>Dosage</i>	<i>Frequency (how many pills in a 24 hours)</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## ALLERGIES

Please list any **allergies or adverse reactions** you have to medications:

<i>Medication</i>	<i>What Happened?</i>
_____	_____
_____	_____
_____	_____

# FAMILY HISTORY

Is your father alive?  Yes  No IF YES, age and any major medical problems? \_\_\_\_\_  
IF NO, age at time of death? \_\_\_\_\_ What major medical problems did he have? \_\_\_\_\_  
Is your mother alive?  Yes  No IF YES, age and any major medical problems? \_\_\_\_\_  
IF NO, age at time of death? \_\_\_\_\_ What major medical problems did she have? \_\_\_\_\_  
Any siblings?  Yes  No How many? \_\_\_\_\_

# SOCIAL HISTORY

**Marital Status:**  Married  Single  Divorced  Widowed  Living with other  
**Education level achieved:**  Grade School  Jr. High  High School  College  Post. Graduate  
**DO you currently smoke cigarettes?**  Yes  No **Number of Years Smoked:**   **For Dr. Use Only** p yrs    
**Packs per Day:** (Please choose the closest)  < 1/2  1/2  1  2  > 2  
**DID you smoke cigarettes in the past?**  Yes  No **Number of Years Smoked:**   **Quit Date:**   /   /     
**Packs per Day:** (Please choose the closest)  < 1/2  1/2  1  2  > 2  
**Do you use any other tobacco products?**  Yes  No **What kind?** \_\_\_\_\_ **Quantity:** \_\_\_\_\_  
**Do you use any recreational drugs?**  Yes  No **What kind?** \_\_\_\_\_  
**Do you drink alcohol?**  Yes  No **Drinks per Day:**   **Drinks per Week:**   **Years:** \_\_\_\_\_  
**DO YOU HAVE OR HAVE YOU HAD an unhealthy relationship with alcohol?**  Yes  No  
**Type of alcohol consumption:**  Beer  Wine  Mixed Drinks

# WORK HISTORY

**Are you currently:**  employed  unemployed  retired  on sick leave  on disability  a stay at home parent  
**Has your job changed since your symptoms started?**  Yes  No  Not Working  
**If you are at a different job or not working, did your symptoms play a role in your job change or decision not to work?**  Yes  No  
**If you are working, are you on:**  Normal duties  Light duties  
**If you are on light duty, did your current symptoms play a role?**  Yes  No  
**Are you applying for disability?**  Yes  No  
**Please describe your job** \_\_\_\_\_

# WORKMAN'S COMPENSATION HISTORY

**IS THIS A WORKERS COMPENSATION CASE?**  Yes  No  
**Have you had any PRIOR workers compensation injuries?**  Yes  No **If yes, how many?**    
**Please list any prior workers compensation cases/injuries:**

Date	Area Injured	Time off Work	Who Treated You?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Were you at work when your symptoms began?**  Yes  No  
**Did you have a specific accident or injury while at work to cause your symptoms?**  Yes  No  
**What is the company name?** \_\_\_\_\_  
**Prior to your WC injury, how long had you been employed by that company?**   months OR   years  
**Do you currently have an attorney for this episode?**  Yes  No

# CAR ACCIDENTS

WERE YOUR SYMPTOMS CAUSED BY A CAR ACCIDENT?  Yes  No

Have you had any PRIOR car accidents?  Yes  No If yes, how many?

Please list: 

Date	Area Injured	Time off Work	Who Treated You?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you currently have an attorney for this episode?  Yes  No

## REVIEW OF SYSTEMS

Check No or Yes in the following areas. If "Yes," please describe:

### 1. CONSTITUTIONAL

- A. Recent weight change?  Yes  No \_\_\_\_\_
- B. Change or loss of appetite?  Yes  No \_\_\_\_\_
- C. Fevers?  Yes  No \_\_\_\_\_
- D. Chills?  Yes  No \_\_\_\_\_
- E. Night sweats?  Yes  No \_\_\_\_\_
- F. Weakness fatigue  Yes  No \_\_\_\_\_

### 2. EYES

- A. Vision change?  Yes  No \_\_\_\_\_
- B. Glasses/contacts?  Yes  No \_\_\_\_\_
- C. Glaucoma?  Yes  No \_\_\_\_\_
- D. Eye infections (iritis)?  Yes  No \_\_\_\_\_
- E. Loss of vision?  Yes  No \_\_\_\_\_

### 3. EARS, NOSE, AND THROAT

- A. Decrease or loss of hearing?  Yes  No \_\_\_\_\_
- B. Ear ache or infection?  Yes  No \_\_\_\_\_
- C. Tinnitus (ringing in ear)?  Yes  No \_\_\_\_\_
- D. Nasal stuffiness/discharge?  Yes  No \_\_\_\_\_
- E. Nosebleeds?  Yes  No \_\_\_\_\_
- F. Sore throat?  Yes  No \_\_\_\_\_
- G. Hoarseness?  Yes  No \_\_\_\_\_
- H. Dental problems?  Yes  No \_\_\_\_\_
- I. Dentures?  Yes  No \_\_\_\_\_
- J. Difficult swallowing?  Yes  No \_\_\_\_\_

### 4. CARDIOVASCULAR

- A. Chest pain?  Yes  No \_\_\_\_\_
- B. Shortness of breath?  Yes  No \_\_\_\_\_
- C. Palpitations?  Yes  No \_\_\_\_\_
- D. Swelling in the legs?  Yes  No \_\_\_\_\_

E. PLEASE LIST MOST RECENT HEART TESTS WITH NAME OF FACILITY, DATE, AND CONTACT PHONE NUMBER

\_\_\_\_\_

### 5. RESPIRATORY

- A. Cough?  Yes  No \_\_\_\_\_
- B. Wheezing/asthma?  Yes  No \_\_\_\_\_
- C. Pneumonia or bronchitis?  Yes  No \_\_\_\_\_
- D. Shortness of breath?  Yes  No \_\_\_\_\_

**6. GASTROINTESTINAL**

- A. Abdominal pain?  Yes  No \_\_\_\_\_
- B. Nausea or vomiting?  Yes  No \_\_\_\_\_
- C. Constipation?  Yes  No \_\_\_\_\_
- D. Diarrhea?  Yes  No \_\_\_\_\_
- E. Heartburn/acid reflux?  Yes  No \_\_\_\_\_
- F. Rectal bleeding or black, tarry stools?  Yes  No \_\_\_\_\_

**7. GENITOURINARY**

- A. Increase frequency of urination?  Yes  No \_\_\_\_\_
- B. Pain/burning when you urinate?  Yes  No \_\_\_\_\_
- C. Frequent infection of urine?  Yes  No \_\_\_\_\_
- D. Incontinence (loss of control)?  Yes  No \_\_\_\_\_
- E. Reduced force of urination?  Yes  No \_\_\_\_\_

**8. MUSCULOSKELETAL**

- A. Muscle aches?  Yes  No \_\_\_\_\_
- B. Joint pains/stiffness (arthritis)?  Yes  No \_\_\_\_\_
- C. Swelling of joints?  Yes  No \_\_\_\_\_

**9. SKIN**

- A. Rash?  Yes  No \_\_\_\_\_
- B. Lumps or sores?  Yes  No \_\_\_\_\_
- C. Changes in hair or nails?  Yes  No \_\_\_\_\_
- D. Dryness?  Yes  No \_\_\_\_\_
- E. Ulcers?  Yes  No \_\_\_\_\_
- F. Abnormal scars?  Yes  No \_\_\_\_\_

**10. NEUROLOGICAL**

- A. Headaches?  Yes  No \_\_\_\_\_
- B. Fainting/blackouts?  Yes  No \_\_\_\_\_
- C. Tremors/involuntary movements?  Yes  No \_\_\_\_\_
- D. Numbness, tingling?  Yes  No \_\_\_\_\_
- E. Dizziness?  Yes  No \_\_\_\_\_
- F. Muscle weakness?  Yes  No \_\_\_\_\_

**11. PSYCHIATRIC**

- A. Depression?  Yes  No \_\_\_\_\_
- B. Mood swings?  Yes  No \_\_\_\_\_
- C. Anger?  Yes  No \_\_\_\_\_
- D. Nervousness/anxiety?  Yes  No \_\_\_\_\_

**12. ENDOCRINE**

- A. Excessive thirst or hunger?  Yes  No \_\_\_\_\_
- B. Hot/cold intolerance?  Yes  No \_\_\_\_\_
- C. Hot flashes?  Yes  No \_\_\_\_\_

**13. HEMATOLOGICAL**

- A. Easy bruising or bleeding?  Yes  No \_\_\_\_\_
- B. Past blood transfusions?  Yes  No \_\_\_\_\_