Mount Sinai Beth Israel

MOUNT SINAI – BETH ISRAEL
SPINE INSTITUTE OF NEW YORK
10 UNION EAST, SUITE 5P
NEW YORK, NY 10003
TEL. (212) 844-8680
FAX. (212) 844-8681

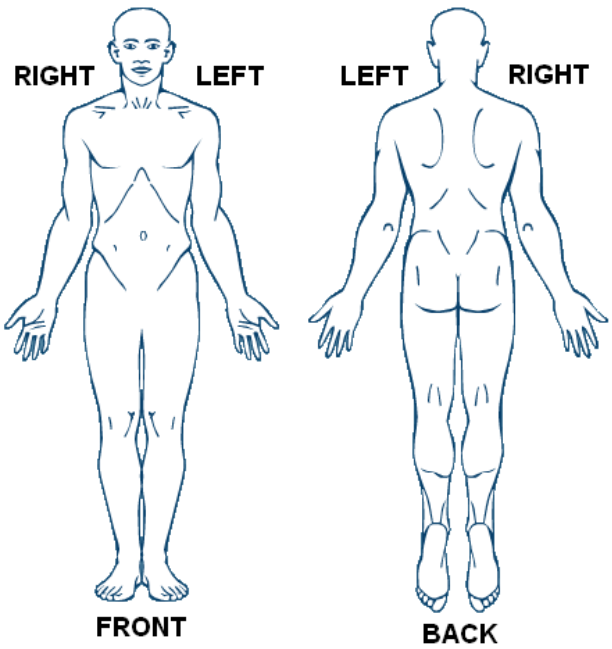
WELCOME TO THE OFFICE OF DR. MICHAEL R. NICOLETTI

TODAY'S DATE: _____

PATIENT NAME: _____ **AGE:** _____ **DATE OF BIRTH:** _____
CHIEF COMPLAINT: _____
DATE OF INURY OR SYMPTOM ONSET: _____
DESCRIBE THE PROBLEM: _____
_____
_____

PLEASE COMPLETE THE FOLLOWING PAIN DIAGRAM

MARK USING X'S, LINES, AND/OR ARROWS WHERE YOU ARE FEELING PAIN RIGHT NOW



RATE YOUR PAIN (CIRCLE THE CORRESPONDING NUMBER)

0 = NO PAIN	10 = EXTREME PAIN
RIGHT NOW:	0 1 2 3 4 5 6 7 8 9 10
AT BEST:	0 1 2 3 4 5 6 7 8 9 10
AT WORST:	0 1 2 3 4 5 6 7 8 9 10

WHAT MAKES THE PAIN BETTER?

_____
_____

WHAT MAKES THE PAIN WORSE?

_____
_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING TESTS FOR THIS PROBLEM? (PLEASE INLCUDE DATES)

X-RAY: _____ **BONE DENSITY:** _____
MRI: _____ **MYELOGRAM:** _____
CT SCAN: _____ **ULTRASOUND:** _____

PATIENT NAME: _____ **TODAY'S DATE:** _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING TREATMENTS FOR <u>THIS</u> PROBLEM? (PLEASE INLCUDE DATES)

MEDICATIONS: _____ **PHYSICAL THERAPY:** _____
INJECTIONS: _____ **SURGERY:** _____
CHIROPRACTIC: _____ **ACUPUNCTURE:** _____
OTHER: _____

<u>MEDICAL HISTORY</u>

DO YOU HAVE ANY ONGOING OR PAST MEDICAL CONDITIONS?

_____

_____

HAVE YOU HAD ANY SURGERY IN THE PAST?

_____

_____

LIST ANY CURRENT MEDICATIONS (INCLUDING VITAMINS/HERBS/SUPPLEMENTS) AND DOSES:

_____

_____

DO YOU TAKE ANY BLOOD THINNERS (INCLUDING COUMADIN OR ASPIRIN) DAILY? YES / NO

<u>ALLERGIES</u> LIST ANY MEDICATION ALLERGIES AND THE REACTIONS: _____

_____

DO YOU HAVE ANY ALLERGIES TO CONTRAST DYE? □ **YES** □ **NO**

DOES ANYONE IN YOUR FAMILY HAVE ANY OF THE FOLLOWING PROBLEMS?

□ **HEART DISEASE** □ **HIGH BLOOD PRESSURE** □ **CANCER** □ **BLEEDING PROBLEMS**
□ **DIABETES** □ **ANESTHESIA COMPLICATIONS** □ **STROKE** □ **NERVE PROBLEMS**
□ **OTHER:** _____

<u>HEALTH HABITS AND SOCIAL HISTORY</u>

MARITAL STATUS: □ **SINGLE** □ **MARRIED** □ **WIDOW/WIDOWER**
CHILDREN: □ **YES** □ **NO** **IF YES, HOW MANY** _____ **HOW OLD** _____
DO YOU SMOKE? □ **YES** □ **NO** **PACKS/DAY** _____ **HOW LONG** _____ **YEARS**
DO YOU DRINK ALCOHOL? □ **YES** □ **NO** **DRINKS/WEEK** _____
CURRENT EMPLOYMENT: WORKING AS _____ **RETIRED FROM** _____
DO YOU EXERCISE? □ **YES** □ **NO** **IF YES, WHAT TYPE?** _____ **HOW OFTEN?** _____

DO YOU HAVE A PRIMARY CARE PHYSICIAN? □ **YES** □ **NO**
NAME: _____ **PHONE:** _____ **FAX:** _____
PHARMACY NAME: _____ **PHONE:** _____

PLEASE LIST SOME QUESTIONS OR TOPICS YOU WISH TO DISCUSS DURING THE CONSULTATION:

_____

_____