

**BLACK HILLS NEUROSURGERY & SPINE**

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**Please complete this questionnaire and bring it with you to your appointment**

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Dominant Hand:  Right  Left

Family/primary doctor(s): \_\_\_\_\_

Who made this appointment for you?:  Self  Physician – name: \_\_\_\_\_

**History of Present Illness:** Please briefly describe your current symptoms. (e.g. low back pain and/or leg pain, neck pain and/or arm pain, etc.) \_\_\_\_\_  
\_\_\_\_\_

Date symptoms began: \_\_\_\_\_ Is this related to an accident/injury?  Yes  No

Date of injury: \_\_\_\_\_ Is this a work related injury?  Yes  No

Is a lawsuit planned or in progress?  Yes  No Name of Attorney: \_\_\_\_\_

**List all previous spine surgeries you have had.** Include procedure/surgery, surgeon, and approximate date:

PROCEDURE/SURGERY	SURGEON	APPROXIMATE DATE

Please list all other providers/physicians whom you've seen **for this problem**. List tests/procedures performed.

DATE	DOCTOR	TESTS/PROCEDURES	LOCATION

Have you had physical therapy for **this problem**?  Yes  No Facility: \_\_\_\_\_

Starting date: \_\_\_\_\_ Ending date: \_\_\_\_\_

Have you had chiropractic care for **this problem**?  Yes  No Provider: \_\_\_\_\_

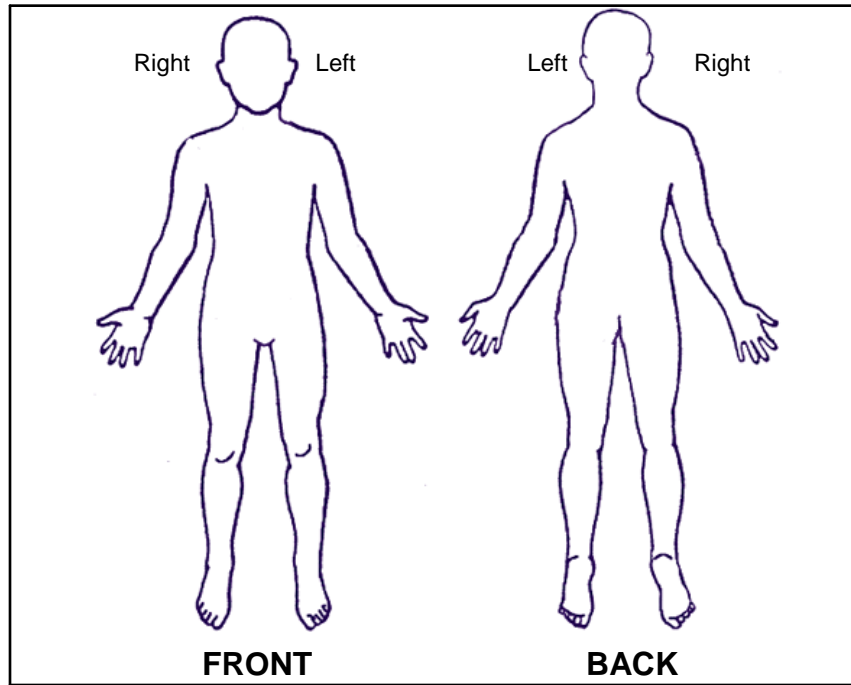
**Do you have any MEDICATION ALLERGIES or other allergies?**  Yes  No **LATEX ALLERGY?**  Yes  No

List medications/allergens and type of reaction. (e.g. Motrin -rash, stomach upset, etc.)  
\_\_\_\_\_  
\_\_\_\_\_

Please list **ALL** medications you are currently taking and dosages, include over-the-counter medications/herbal supplements.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Physician Use only:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please mark areas of pain, numbness, tingling



**HABITS**

Do you/have you smoked cigarettes?  Yes  No How many packs/day? \_\_\_\_\_ # of years? \_\_\_\_\_

When did you quit? \_\_\_\_\_ Do you chew tobacco?  Yes  No # of cans/week? \_\_\_\_\_

Do you use alcohol?  Yes  No How much/how often? \_\_\_\_\_

Do you use "street" drugs?  Yes  No Type? \_\_\_\_\_

**SURGERIES**

Please list ALL other surgeries you have had. Include surgeon and approximate date.

SURGERY	SURGEON	APPROXIMATE DATE

**SOCIAL HISTORY**

Are you?  married  single  widowed  divorced Are you employed?  Yes  No

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

When was your last day of work? \_\_\_\_\_ Are you retired?  Yes  No

Are you receiving disability?  Yes  No First date of disability: \_\_\_\_\_

**FAMILY HISTORY**

Please list family members, living and deceased, their ages, and any **MAJOR** health problems?

**Father:**  living  deceased, age \_\_\_\_\_ health problems? \_\_\_\_\_

**Mother:**  living  deceased, age \_\_\_\_\_ health problems? \_\_\_\_\_

**Sister(s):** # living \_\_\_\_\_ # deceased \_\_\_\_\_ health problems? \_\_\_\_\_

**Brother(s):** # living \_\_\_\_\_ # deceased \_\_\_\_\_ health problems? \_\_\_\_\_

**Daughter(s):** # living \_\_\_\_\_ # deceased \_\_\_\_\_ health problems? \_\_\_\_\_

**Son(s):** # living \_\_\_\_\_ # deceased \_\_\_\_\_ health problems? \_\_\_\_\_

**\*\*ANY KNOWN FAMILY HISTORY OF MALIGNANT HYPERTHERMIA WITH ANESTHESIA ?  Yes  No**

**PAST MEDICAL HISTORY**

Please check any of the following medical conditions that you are currently or have previously been treated for.

GENERAL:

- lupus
- HIV/AIDS
- malignant hyperthermia
- obesity
- MRSA infection
- other \_\_\_\_\_

SKIN:

- acne
- basal cell cancer
- squamous cell cancer
- melanoma
- eczema
- psoriasis
- shingles
- other \_\_\_\_\_

LUNG/RESPIRATORY:

- asthma
- chronic bronchitis
- COPD
- emphysema
- lung cancer
- pulmonary embolus
- sleep apnea
- active tuberculosis
- + TB skin test only
- other \_\_\_\_\_

CARDIAC:

- abdominal aneurysm
- angina
- atrial fibrillation
- cardiac pacemaker
- heart failure (CHF)
- coronary artery disease
- high blood pressure
- high cholesterol
- heart attack (MI)
- mitral valve prolapse
- other \_\_\_\_\_

BREAST:

- breast cancer
- fibrocystic breast
- other \_\_\_\_\_

GENITOREPRODUCTIVE:

- cervical cancer
- ovarian cancer
- uterine cancer
- endometriosis
- other \_\_\_\_\_

GENITOURINARY:

- benign prostatic hypertrophy (BPH)
- chronic renal failure
- prostate cancer
- testicular cancer
- other \_\_\_\_\_

GASTROINTESTINAL:

- cirrhosis
- colon cancer
- crohn's disease
- diverticulosis
- reflux disease (GERD)
- hiatal hernia
- hepatitis, A or B
- hepatitis C
- irritable bowel syndrome
- pancreatitis
- ulcerative colitis
- ulcers
- other \_\_\_\_\_

MUSCULOSKELETAL:

- fibromyalgia
- gout
- osteoarthritis
- osteoporosis
- rheumatoid arthritis
- other \_\_\_\_\_

CIRCULATION/VASCULAR:

- deep vein thrombosis (DVT/blood clot)
- peripheral artery disease
- raynaud's disease
- other \_\_\_\_\_

NEUROLOGIC:

- alzheimer's disease
- dementia
- diabetic neuropathy
- migraine headaches
- multiple sclerosis
- parkinson's disease
- seizures/epilepsy
- stroke
- TIA
- other \_\_\_\_\_

PSYCHIATRIC:

- anxiety
- bipolar disorder
- depression
- PTSD
- other \_\_\_\_\_

ENDOCRINE:

- diabetes
- hyperthyroidism
- hypothyroidism
- other \_\_\_\_\_

HEMATOLOGIC:

- anemia
- factor V (Leiden)
- hodgkin's lymphoma
- leukemia
- von Willebrand's
- other \_\_\_\_\_

Please provide any additional information that may help us with your examination: \_\_\_\_\_

\_\_\_\_\_

## REVIEW OF SYSTEMS

Please check any of the following symptoms that you are **CURRENTLY** experiencing. Please provide an explanation in the space below:

### GENERAL/SYSTEMIC:

- chills
- fevers
- night sweats
- unexplained weight gain
- unexplained weight loss

### HEENT:

- headache
- sinus pain
- vision problems
- swollen glands
- enlarged neck (goiter)
- bleeding gums
- hearing loss
- hoarseness
- mouth sores
- nose bleeds
- snoring
- ringing in ears

### BREAST:

- Pain
- Discharge
- Lumps

### CARDIOVASCULAR:

- chest pain
- claudication (leg pain w/ exercise/activity)
- palpitations

### PULMONARY:

- cough
- coughing up blood
- coughing up phlegm
- shortness of breath
- shortness of breath with lying flat
- wheezing

### GASTROINTESTINAL:

- abdominal pain
- rectal bleeding
- black or bloody stools
- constipation
- diarrhea
- swallowing difficulty
- heartburn
- nausea
- vomiting

### GENITOURINARY:

- painful urination
- increased urinary frequency
- bloody urine
- urinary urgency
- frequent nighttime urination
- currently/possibly pregnant
- date of last menstrual period: \_\_\_\_\_

### ENDOCRINE:

- excessive thirst
- generalized muscle weakness

### HEMATOLOGIC:

- bleed easily
- bruise easily

### MUSCULOSKELETAL:

- edema
- muscle aches
- joint pain
- joint stiffness
- joint swelling

### NEUROLOGIC:

- dizziness
- vertigo
- fainting (syncope)
- convulsions
- lightheadedness
- memory loss/lapses

### PSYCHIATRIC:

- anxiety
- depression
- insomnia

### SKIN:

- dry skin
- itching
- rashes

Please provide any additional information that may help us with your examination: \_\_\_\_\_

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**HEALTH CARE MAINTENANCE**

When was your last blood sugar screening? \_\_\_\_\_ Results: \_\_\_\_\_

When was your last cholesterol screening? \_\_\_\_\_ Results: \_\_\_\_\_

When was your last EKG/Stress test? \_\_\_\_\_ Results: \_\_\_\_\_

When was you last CXR? \_\_\_\_\_ Results: \_\_\_\_\_

When was your last Colon Screening test (hemocult, colonoscopy, etc.)? \_\_\_\_\_

Results: \_\_\_\_\_

Have you had an Osteoporosis screening test within the past two years?  Yes  No

Results: \_\_\_\_\_

When was your last Tetanus immunization? \_\_\_\_\_

**Females:**

When was your last Pap smear? \_\_\_\_\_ Results: \_\_\_\_\_

When was your last Mammogram? \_\_\_\_\_ Results: \_\_\_\_\_

**Males:**

When was your last Prostate exam? \_\_\_\_\_ Results: \_\_\_\_\_

When was your last Prostate Cancer screen (PSA test)? \_\_\_\_\_ Results: \_\_\_\_\_

X \_\_\_\_\_

*Patient's Signature*

\_\_\_\_\_ *Date*

**PHYSICIAN/PA USE ONLY**

**I have reviewed the information contained in this form with the patient**

\_\_\_\_\_  
Provider's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider's Signature

\_\_\_\_\_  
Date