Maine Medical
PARTNERS
Neurosurgery & Spine
A department of Maine Medical Center
www.mainemedicalpartners.org

49 Spring Street, Scarborough, ME 04074

Medical History Questionnaire

Patient Name: ______________________________ Date: ______________

Date of Birth: ______________ Age: ________ Height: ________ Weight: ________

1. Is this condition work related?: ❏ Yes ❏ No Date of Injury: ___/___/___
2. In a few words, please describe your medical concerns: ______________________________

____

3. Is this your first episode?: ❏ Yes ❏ No
4. Have you had similar symptoms or injuries before? (briefly list): ______________________________

____

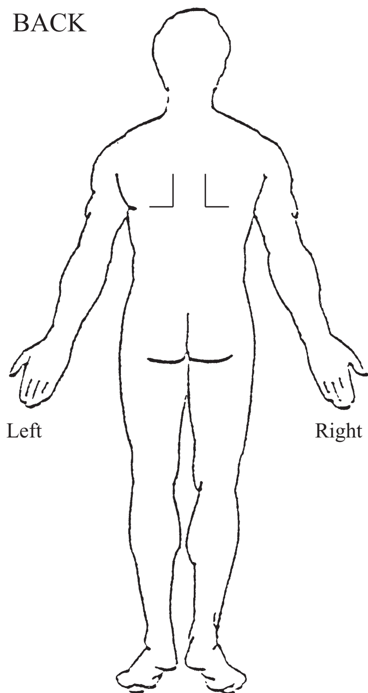
5. Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas.

Aching	Numbness	Pins and Needles	Burning	Stabbing	Other
Δ Δ Δ	= = =	o o o	x x x	/ / /	# # #

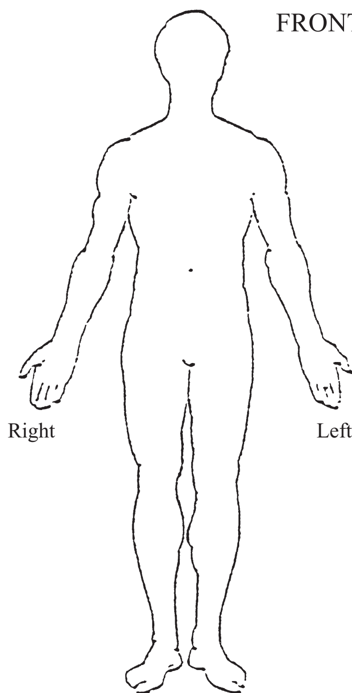
Please rate your pain in each location:

0 = no pain 10 = worst imaginable

BACK



FRONT



1. 0 ———————— 10
2. 0 ———————— 10

PHYSICIAN'S NOTE:

6. What makes the symptoms better?: ______________________________

____

7. What makes the symptoms worse?: ______________________________

____

Please complete reverse side

8. Please list all current and prior medical problems and prior surgeries (with date): ______________________________

____

9. Please list all medications: ______________________________

____

10. List any allergies or bad reactions to drugs, foods, dyes, latex, rubber goods: ______________________________

____

11. Are you ❑ Married ❑ Single ❑ Partner ❑ Divorced ❑ Widowed ❑ Children How many? ______

12. Smoking ______ packs a day. If quit, when? ________________

Alcoholic Beverages Daily ____________

13. What is your highest grade completed? ________

14. Work History:

Employer: ______________________ Job Title: ________________ Date of Hire (current job): ____________

Last date full duty: ________________ Hours per week: ____________

Are you receiving Worker's Compensation?: ❑ Yes ❑ No

Is there litigation or lawyers involved?: ❑ Yes ❑ No

If yes, briefly explain: ______________________________

15. Family History:

Mother: ❑ Living ❑ Deceased If deceased, of what?: ______________________

Father: ❑ Living ❑ Deceased If deceased, of what?: ______________________

What medical problems are in your family?

❑ Cancer ❑ Diabetes ❑ Heart Disease

❑ Bleeding Disorders ❑ Heart Murmur ❑ Thyroid Disorder

❑ Other: ______________________________

16. Does anyone in your family have chronic pain or disability?: ______________________________

Review of System - To Be Completed by Patient - Do you or have you ever had?

Head, Eyes, Ears, Nose and Throat:

- ❑ Glaucoma
- ❑ Cataracts
- ❑ Double Vision
- ❑ Blindness
- ❑ Dizzy Spells
- ❑ Fainting Spells
- ❑ Severe Headache
- ❑ Deafness
- ❑ Ringing in Ears
- ❑ Sores in Mouth
- ❑ Nose Bleeds
- ❑ Difficulty Swallowing
- ❑ Difficulty Sleeping

Cardiovascular, Respiratory:

- ❑ Heart failure
- ❑ Chest Pain
- ❑ Persistent swelling in ankles
- ❑ High Blood Pressure
- ❑ Emphysema
- ❑ Asthma
- ❑ Chronic Cough
- ❑ Coughing up blood
- ❑ Shortness of breath on exertion

Gastrointestinal:

- ❑ Weight Loss
- ❑ Weight Gain
- ❑ Chronic Heartburn
- ❑ Ulcers
- ❑ Prior Alcohol/Drug Treatment
- ❑ Liver Disease
- ❑ Cirrhosis
- ❑ Loss of Appetite
- ❑ Irregular Bowels
- ❑ Constipation
- ❑ Bloody Stools
- ❑ Caffeine Beverages Daily

Endocrine:

- ❑ Diabetes
- ❑ Excessive Thirst
- ❑ Thyroid
- ❑ Gout
- ❑ Rheumatism
- ❑ Arthritis
- ❑ Growth Problems
- ❑ Stress
- ❑ Sensitive to hot or cold environment
- ❑ Recent swelling in hands and feet
- ❑ Broken Bones

Genito-urinary:

- ❑ Bloody Urine
- ❑ Venereal Disease
- ❑ Bladder Infections
- ❑ Kidney Disease
- ❑ Frequent Urination
- ❑ Painful Urination
- ❑ Loss of Urine on sneezing or coughing

Coagulation:

- ❑ Frequent Bruising
- ❑ Abnormal Clotting
- ❑ Abnormal Bleeding
- ❑ Blood Thinners
- ❑ Bleeding after other operations
- ❑ Aspirin

Orthopaedic/Neurologic:

- ❑ Joint Pain
- ❑ Tremors
- ❑ Stroke
- ❑ Depression
- ❑ Seizures
- ❑ Anxiety
- ❑ Loss of Coordination
- ❑ Paralysis of any part
- ❑ Nerve Disorder or "Nerve Troubles"

Patient Signature: ______________________________ Physician Signature: ______________________________