A PHYSICIAN OWNED HOSPITAL

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Thank you for choosing Dr Jacob Archer as your Neurosurgical Provider. We look forward to supplying you the highest quality neurosurgical care in a professional and friendly manner. Before coming to your office appointment please remember the following:

1. Complete the attached questionnaire and FAX or MAIL it back as soon as possible.

2. It is ESSENTIAL for you to bring your IMAGING CD'S. Your referring provider may send a copy of the radiology report. It is your responsibility to provide our office with the actual films or CD's. If they are not available, we may be forced to reschedule your appointment.

3. To bring your INSURANCE CARD(s) / DRIVER'S LICENSE.

4. To bring copies of your medical RECORDS.

If you have any questions, please feel free to contact our office. We look forward to meeting you.

Oklahoma Spine Hospital

Patient's Name:____
First Middle Last

SS#: ____________________ Date of Birth:___________________ Age:______ Sex: ☐ M ☐ F

Email:__________________________

Patient's Address: ____

City:__________________________________ State:_____________________ Zip:_______________

Patient's Home #: _____ __ ____________ Work #: _____ _ ____________Cell #: _____ _ ____________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse Name:__________________ Work #: ___________________ Cell #: ________________

Emergency Contact (Other Than Your Spouse) Name:_______________________________________

Relation:______________________________________ Phone #: ____________________________

Ethnicity : ☐Hispanic or Latino ☐ Not Hispanic or Latino ☐Decline to specify

Primary Language:________________________ Race: __________________________________

Level of Education: ☐Post Graduate Degree ☐College Degree ☐Some College ☐High School Grad ☐Other

****If you were injured:** ☐Auto Accident ☐ On the job ☐ Other_____________________________
Date of Injury ____________
If applicable, Attorney's Name: ____________________________ Phone #:______________________

Patient Work Status**:** Employer: _________________________________Job Title: ________________

☐ Retired from: ____

☐ Unemployed. Last employment and when: ____

☐ Long Term Disability, if so, what is disability: ____

☐ Work Comp, Employed by & time on the job prior to injury: __________________________________

List all previous Work Comp injuries and dates: ____

Current work Status: ☐ Light Duty ☐ TTD ☐ No Longer Employed ☐ Full Duty

Who referred you to us: ____

Address____ Ph. ___________________

Family Provider: ____

Address:____Ph.___________________

This information is required for our office to file your Health Insurance

Not for WORKERS COMP

Primary Insurance Information:

Insurance Name: ____

ID Number: ______________________________ Group Number: ______________________________

Claims Address: ____

Relationship to Insured: ____

If insured is someone other than patient, Insured's Name: ____

Insured's date of birth: ___________________________ Insured's SSN __________________________

Insured's Employer: ____

Secondary Insurance Information:

Insurance Name: ____

ID Number: ______________________________ Group Number: ______________________________

Claims Address: ____

Relationship to Insured: ____

If insured is someone other than patient, Insured's Name: ____

Insured's date of birth: ___________________________ Insured's SSN __________________________

Insured's Employer: ____

Tertiary Insurance Information:

Insurance Name: ____

ID Number: ______________________________ Group Number: ______________________________

Claims Address: ____

Relationship to Insured: ____

If insured is someone other than patient, Insured's Name: ____

Insured's date of birth: ___________________________ Insured's SSN __________________________

Insured's Employer: ____

Name_______________________

1. Date your symptoms began: ___________________

2. Please describe the type of medical problem or symptoms that you are being seen for today:

1.________________ 2.________________ 3.________________ 4.__________________

3. If your symptoms were because of an accident or injury, please explain:______________________

____

4. Are your symptoms: ☐ Improving ☐ Resolved ☐ Unchanged ☐ Worsening

Current level of pain on the following scale:(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Intolerable)

As best as you can, describe your symptoms in terms of: Location:

____

Does the pain move or radiate anywhere:____

Check any that apply, otherwise assumed as no.

Timing of symptoms	Description of symptoms	Aggravators of symptoms
☐ Constant	☐ Aches	☐ Coughing
☐ Occasional	☐ Throbs	☐ Sneezing
☐ Wake you up	☐ Burns	☐ Walking
☐ During activity	☐ Tingles	☐ Sleeping
	☐ Stabbing	☐ Bending or Stooping

5. If you're weak, describe where and the degree of weakness:_______ __________________________

What makes your condition worse?____

What helps your condition?____

Other body parts affected:____

Have you had any treatment or surgeries for your current condition?

☐ Physical Therapy ☐ Epidural Steroids ☐ Chiropractic Care ☐ Traction ☐ Other:________________

Has there been any change in bowel or bladder function? ☐Yes ☐No

6. Do you now or have you ever had the following:

☐Heart disease ☐CAD – Coronary Artery Disease

☐Lung disorder ☐PVD – Peripheral Vascular Disease

☐Kidney disease ☐Anxiety

☐Mental disease ☐Multiple sclerosis

☐Clotting disorder ☐COPD – Chronic Obstructive Pulmonary Disease

☐Cancer

☐Arthritis

☐Osteoporosis

Other:____

Name________________________

7. Please list all surgeries you have had including the year they were performed:

☐ Appendectomy Date:___________
☐ Pacemaker Date:___________
☐ Carpal Tunnel Release Date:___________
☐ Hernia Repair Date:___________
☐ Hip Replacement Date:___________
☐ Hysterectomy Date:___________

☐ Tonsillectomy Date:___________
Discectomy ☐-Cervical ☐-Thoracic ☐-Lumbar
Date:___________
Spinal Fusion ☐-Cervical ☐-Thoracic ☐-Lumbar
Date:___________

Other surgeries: ____

8. Please list any medications that you are currently taking. List the name of the medicine, the dosage, frequency, and route:

Name	Dosage	Frequency	Route

9. List ANY allergies you may have, including METALS: ☐ **NO KNOWN ALLEGIES**

☐Aspirin	☐Hydrocodone	☐Morphine
☐Amoxicillin	☐Ibuprofen	☐**Nickel**
☐Bactrim	☐Iodine	☐Oxycodone
☐**Cobalt**	☐Ketalar	☐Penicillin
☐**Chromium**	☐Ketamine	☐Sulfa
☐Codeine	☐Latex	☐**Titanium**
☐Demerol	☐Meprobamate	☐Tramadol

OTHER:____

Name___________________________

10. Social History

Tobacco use: ☐ Current ☐ Never ☐ Former ☐ Unknown

Type ______________________________
Number of years ______________________________
Packs per day ______________________________
Tobacco per day ______________________________
Ever tried to quit: ☐ Yes ☐ No
Year quit ______________________________
Passive smoke exposure: ☐ Yes ☐ No

Alcohol Use: ☐ Yes ☐ No ☐ Formerly
Type ______________________________
Frequency ______________________________
Amount ______________________________
Last Drink ______________________________
Year Quit ______________________________

Illegal Drugs: ☐ Yes ☐ No How much________________ Type______________________

11. Has anyone in your immediate family had:

	Yes	Mother	Father	Sister	Brother
High Blood Pressure	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐

Name________________________

Review of Systems

Are you currently experiencing any of the following symptoms? If yes please check the box next to the symptoms, all unmarked answers well be recorded as a no.

General
- ☐ Weakness
- ☐ Tiredness
- ☐ Lack of appetite
- ☐ Weight gain
- ☐ Chills
- ☐ Fever
- ☐ Night sweats
- ☐ Difficulty in sleeping

Genito Reproductive (Male)
- ☐ Sexually transmitted disease
- ☐ Decreased sexual drive
- ☐ Discharge from penis
- ☐ Testicular pain
- ☐ Lumps in testicles or scrotum
- ☐ Decrease in testicular size
- ☐ Difficulty achieving erection
- ☐ Taking male hormones

Genito Reproductive (Female)
- ☐ Sexually transmitted disease
- ☐ Decreased sexual drive
- ☐ Do you have menstrual irregularities
- ☐ Are you bothered by hot flashes
- ☐ Taking female hormones

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Heartburn
- ☐ Abdominal Pain
- ☐ Bright red blood in stools
- ☐ Black stools

Endocrine
- ☐ Goiter
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Tremulousness of the hands
- ☐ Change in pitch of the voice
- ☐ Increased body hair
- ☐ Decreased body hair
- ☐ Increased thirst
- ☐ Increase in appetite

Urinary
- ☐ Incontinence of urine
- ☐ Pain or burning when urinating
- ☐ Frequent urination - day
- ☐ Frequent urination - night
- ☐ Urinary Tract Infection
- ☐ Extreme urge to urinate
- ☐ Difficulty starting urination
- ☐ Difficulty stopping stream
- ☐ Kidney stones

Cardiovascular
- ☐ Have you ever seen a heart specialist
- ☐ Chest pain, tightness or squeezing
- ☐ Heart attack
- ☐ Shortness of breath lying down
- ☐ Need to sit up to breathe
- ☐ Heart Racing
- ☐ Irregular heart beat (Palpitations)
- ☐ Heart murmur
- ☐ Swelling of the legs
- ☐ Varicose Veins
- ☐ Leg pain at rest
- ☐ Leg pain with exertion
- ☐ Blue/Purple hands or feet

Respiratory
- ☐ Cough
- ☐ Wheezing
- ☐ Asthma
- ☐ Shortness of breath at rest
- ☐ Shortness of breath with exertion
- ☐ Pain in the chest when you cough, sneeze or move
- ☐ Sleep apnea

Eyes, Ears, Nose, Throat
- ☐ Pain in the eyes
- ☐ Difficulty in hearing
- ☐ Ringing in your ears
- ☐ Discharge from the ears
- ☐ Nasal discharge (frequent)
- ☐ Hoarseness

Musculoskeletal
- ☐ Muscle pain
- ☐ Neck pain
- ☐ Shoulder or arm pain
  ☐Left ☐Right
- ☐ Back pain
- ☐ Pain down legs
  ☐Left ☐Right
- ☐ Painful joints
- ☐ Swelling of joints
- ☐ Redness of joints
- ☐ Stiffness of joints
- ☐ Deformities of the joints or extremities

Neurologic/Psychiatric
- ☐ Seizures
- ☐ Headaches
- ☐ Blackouts
- ☐ Dizziness
- ☐ Double vision
- ☐ Paralysis or weakness of limbs
- ☐ Loss of sensation
- ☐ Loss of balance
- ☐ Loss of coordination
- ☐ Difficulty in speaking
- ☐ Nervousness
- ☐ Depression
- ☐ Difficulties in going to sleep
- ☐ Early morning awakening
- ☐ Difficulty with memory of past events
- ☐ Difficulty with thinking
- ☐ Difficulty with problem solving
- ☐ Blurred vision
- ☐ Spots before eyes
- ☐ Stroke

Patient Signature___________________________________ **Date**___________________