Stony Brook Orthopaedic Associates
Spine and Scoliosis Center

BACK

Matthew Berchuck, M.D.

Height: _____ft ____ in

Weight: _____ lb

Patient Name: _____

Age: _____

Occupation: _____

History of Present Illness

In your own words, describe the problem you are having?

_____

_____

_____

_____

I was referred by: _____

Primary Care Physician (If different): _____

When did your present pain start? _____

Was this an injury? Yes No Describe: _____

_____

On a scale from 0 (no pain) to 10 (unbearable pain) my pain is currently a _____

How long have you had this pain? _____ years _____ months _____ weeks _____ days

How long have you had similar pain? _____years _____ months _____ weeks _____ days

Are you having any leg pain? Yes No

My leg pain is □ greater than □ less than □ equal to my back pain.

Leg Symptoms:

Right:	Numbness?	Yes	No	Weakness?	Yes	No	Tingling?	Yes No
Left:	Numbness?	Yes	No	Weakness?	Yes	No	Tingling?	Yes No

Do your symptoms awaken you at night? Yes No Sometimes

How far can you walk?_____

Are you having any problems with bowel, bladder or sexual function?

Describe: _____

_____

Have you been losing weight (OTHER THAN DIETING)? Yes No

If yes, how much weight was lost?_____

Treatments:

□ Medications: _____

□ Physical therapy □ Injections □ Other: _____

My symptoms are getting: □ better □ worse □ about the same

My symptoms are: □ present everyday □ constant □ present occasionally

Previous BACK Surgery: (Please indicate year, type of Surgery, and Surgeon, if known)

1.
2.
3.

Testing done:

□ X-rays □ MRI □ EMG/NCV
□ Myelogram with CAT Scan □ CAT Scan □ Other: _____

Do you have any additional information that would be helpful to understand your problem?

_____

_____

Medical History

Do you have any history of:						□None of the following		
AIDS/HIV	Yes	No	Kidney Problems	Yes	No	Stomach Prob(Ulcers, Reflux)	Yes	No
Migraine Headache	Yes	No	High Blood Pressure	Yes	No	Thyroid Disorder	Yes	No
Anemia	Yes	No	Muscle Diseases	Yes	No	Breast Cancer	Yes	No
Arthritis	Yes	No	COPD	Yes	No	Prostate Cancer	Yes	No
Diabetes	Yes	No	Liver disease	Yes	No	Lung Cancer	Yes	No
Epilepsy/Seizure	Yes	No	Hepatitis A/B/C	Yes	No	Thyroid Cancer	Yes	No
Gout	Yes	No	Osteoporosis/Osteopenia	Yes	No	Myeloma	Yes	No
Cancer	Yes	No	Nerve Problems	Yes	No	Lymphoma	Yes	No
Bleeding Problems	Yes	No	Pneumonia	Yes	No	Problems with Anesthesia	Yes	No
Emphysema/Asthma	Yes	No	Psychiatric Disorders	Yes	No	Blood Clots (DVT,PE)	Yes	No
Fibromyalgia	Yes	No	Depression/Anxiety	Yes	No	Rheumatoid Arthritis	Yes	No
Irregular Heartbeat	Yes	No	Stroke	Yes	No	Sleep Apnea	Yes	No
Heart Problems	Yes	No	Polio	Yes	No	Other	Yes	_____

Review of Systems

Do you have any complaints of:						□None of the following	
Chest Pain	□	Constipation	□	Abnormal Bleeding	□	Abnormal Menstrual Cycle	□
Cough	□	Cold Hands/Feet	□	Growth Disturbance	□	Incontinence of Bowel	□
Depression	□	Loss of Appetite	□	Runny Nose	□	Incontinence of Urine	□
Ear Pain	□	Muscle Weakness	□	Numbness of Feet	□	Sleep Disturbance	□
Fainting	□	Impotence	□	Numbness of Hands	□	Sputum Production	□
Fever	□	Balance Problems	□	Shortness of Breath	□	Visual Disturbance	□
Mania	□	Seizures	□	Sore Throat	□	Swelling in the Legs	□
Skin Rash	□	Skin Ulcers	□	Wheezing	□	Unexplained Weight Loss	□
Vomiting	□	Stomach Pain	□	Weight Gain	□	Other _____	

Current Medications (Name and dosage) □ **None**

Do you take antacids? Yes No	

Allergies to Medications:

□ None identified	
Latex Allergy? Yes No	

What other surgeries (OTHER THAN BACK) have you had? What year were they done (approximate)?

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Social History

Do you smoke? Yes No Packs/day?_____ Smokeless varieties_____
How many years have you or did you smoke? _____ When did you quit? _____
Do you drink alcohol? Yes No How much:_____□Social □Daily □____days/week
Marital History: M S D W
Are you currently working? Yes No If not, how long have you been off?_____
Please fill in last grade completed in school: _____

Family History

Does anyone in your family have:							
Osteoporosis/Osteopenia?	Yes	No	Blood Clots?	Yes	No		
Diabetes?	Yes	No	Arthritis?	Yes	No	What joints?	_____
High Blood Pressure?	Yes	No	Cancer?	Yes	No	What type?	_____
Heart Disease?	Yes	No	Tuberculosis	Yes	No		
Mental Disorder	Yes	No					

I certify that the above information is accurate and complete.

_____ Date: _____
Signature of patient