Maine Spine Surgery
195 Fore River Parkway, Suite 440
Portland, ME 04102
207-553-6054

Legal Name____Date: _____________________
First   Middle   Last

Date of Birth:_______________Gender: ❑ Male   ❑ Female SS#:__________-_______- ___________

Mailing Address:___________________________City:________________State:______Zip: _________

Primary Phone :_______________Work Phone:_______________Alternate Phone : ________________

Marital Status:________________Religious Preference: _______________________________________

Occupation:________________________Employer:______________________Status: ❑ FT ❑ PT

Employer Address:__________________________City:________________State:______Zip: ________

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*Primary Care Provider:_____________________Primary Care Provider Phone #:________________

Do you have an advance directive? Y   N

Do you need an interpreter?   Y   N   If yes, what language?___________________________________

How did you hear about our program?____

EMERGENCY CONTACT INFORMATION

Next of Kin:_____________________________________Relationship: _________________________
First   Last

Address :_________________________________City:________________State:______Zip: _________

Primary Phone :_______________May we discuss your medical information with the person? Y   N

Secondary Person to Notify:_______________________________Relationship: __________________
First   Last

Address :_________________________________City:________________State:______Zip: _________

Primary Phone :_______________May we discuss your medical information with the person? Y   N

WORKERS COMPENSATION

If your employer/workers compensation carrier has sent you for evaluation/treatment, please complete the following:

Workers Compensation Carrier:______________________*Claim/File #: ________________________

Date of Injury_______________Workers Compensation Claim Address : __________________________

(Address Continued) City:_______________State:______Zip: _________

Adjuster's Name:_____________________________Adjuster's Contact Phone #: __________________

First Last

Employer Name/Address at Time of Injury:____________City:___________State:_____Zip: ________

MOTOR VEHICLE (MV) ACCIDENT

If you are here as a result of an automobile accident, please complete the following:

MV Insurance Company:__________________Claim #:____________Date of Accident:____________

MV Insurance Address :___________________City:________________State:______Zip: __________

Claim Agent's Name:____________________________Claim Agent's Phone:___________________

First Last

Policy Holder's Name :________________________City:_____________State:_____Zip: _________

First Last

INSURANCE INFORMATION

Please present insurance cards for copying

Primary Insurance:____________Subscriber:_____________________Relationship: _______________

Subscriber's DOB:_________Subscriber's SS#______-_____-______Subscriber's Employer:__________

Secondary Insurance:____________Subscriber:____________________Relationship: ______________

Subscriber's DOB:_________Subscriber's SS#______-_____-______Subscriber's Employer:__________

Maine Spine Surgery
195 Fore River Parkway
Suite 440
Portland, ME 04102
Telephone: 207-553-6054
Fax: 207-553-6076

Medical History Questionnaire

Patient Name:____Date:__________________

Date of Birth:___________________________Age:___________Height:________________Weight:____________

1. Is this condition work related?:________Date of Injury:______________

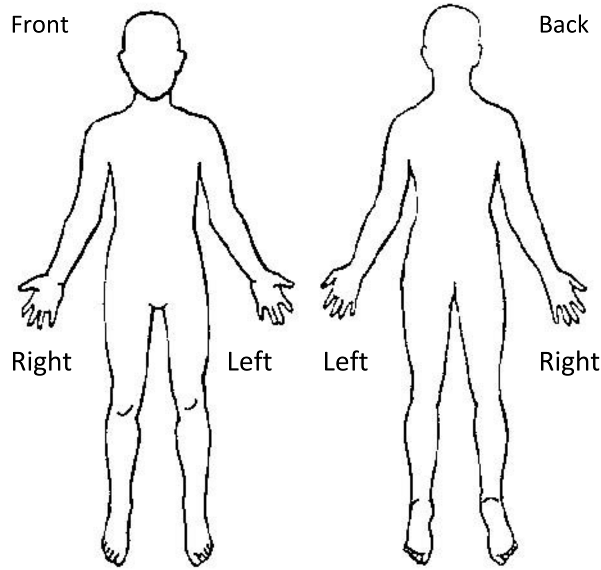
2. In a few works, please describe your medical concerns:____
____

3. Is this your first episode?

4. Have you had similar symptoms or injuries before? (briefly list):_____________________________________
____

5. Using the symbols 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	Please rate your pain in each location 0=no pain 10=worst imaginable
^^^	===	ooo	xxx	///	###	
					1.	|--|
					2.	|--|



PHYSICIAN'S NOTES:

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. Highest grade completed?___________College Years___________Graduate Study Years_______________

13. Work History:
Employer:_________________Job Title______________________Date of Hire (current job):___________
Last date full duty:__________Usual hours per week:___________Current hours per week_____________
Are you receiving Worker's Compensation?: ☐Yes ☐No
Is there litigation or lawyers involved?: ☐Yes ☐No
If yes, briefly explain:____

14. 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:_____________

15. 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?

General	Cardiovascular, Respiratory	Genito – urinary
☐Recent Chills ☐Recent Fever ☐Weight Loss ☐Weight Gain ☐Stress ☐Recent Night Sweats ☐Difficulty Sleeping ☐Caffeine Beverages Daily ☐ Alcohol________Drinks a Day/Week ☐ Smoking________Packs a Day/Week **Head, Eyes, Ears, Nose and Throat** ☐Glaucoma ☐Double Vision ☐Blindness ☐Dizzy Spells ☐Cataracts ☐Nose Bleeds ☐Deafness ☐Sores in Mouth ☐Fainting ☐Severe Headaches ☐Ringing in Ears ☐Difficulty Swallowing	☐Heart Failure ☐Coughing up Blood ☐Chest Pain ☐High Blood Pressure ☐Emphysema ☐Asthma ☐Persistent swelling in ankles ☐Shortness of breath on exertion **Gastrointestinal** ☐Heartburn ☐Bloody Stool ☐Constipation ☐Liver Disease ☐Cirrhosis ☐Loss of Appetite ☐Ulcers ☐Irregular Bowels **Endocrine** ☐Diabetes ☐Thyroid ☐Insulin Pump ☐Excessive Thirst ☐Gout ☐Growth Problems ☐Sensitive to hot or cold environment	☐Bloody Urine ☐Venereal Disease ☐Kidney Disease ☐Bladder Infections ☐Painful Urination ☐Frequent Urination ☐Loss of Urine on sneezing or coughing **Coagulation** ☐Aspirin ☐Blood Thinners ☐Bruising ☐Abnormal Bleeding ☐Abnormal Clotting ☐Bleeding after other operations **Neurologic/Skeletal** ☐Joint Pain ☐Rheumatism ☐Arthritis ☐Broken Bones ☐Tremors ☐Stroke ☐Depression ☐Anxiety ☐Seizures ☐Paralysis ☐Nerve Disorders ☐Loss of Coordination

Patient Signature:____________________________Physician Signature:______________________________