1 Lincoln Parkway, Suite 300
Hattiesburg, MS 39402

Southern Neurologic & Spinal Institute

601-579-4440
601-579-4460

PATIENT QUESTIONNAIRE

TODAY'S DATE:_____

NAME_____ DATE OF BIRTH _____

Referring Physician: _____

Other Neurosurgeon / Orthopedic surgeon / Neurologist / Pain specialist (please list):

1. _____, 2. _____, 3._____,

Medical Problems (such as heart, lung, kidney disease, diabetes, high blood pressure, arthritis, stroke, etc.): _____

_____

Past Surgeries: _____

_____

Medications: _____

_____

_____

Drug Allergies: _____

_____

Family History (include father, mother, brothers and sisters, and children): _____

_____

_____

Social History

Do you smoke? _____ If so, how much and how long: _____

Do you drink? _____ If so, how much and how long: _____

Have you used any recreational drugs in the past year? (circle all that apply)

cocaine marijuana heroin amphetamines other (list) _____

Are you presently involved in a lawsuit or workman's compensation? (If so, please explain) _____

_____

_____

With whom do you live? _____

Work History

Date last employed _____

Employer: _____ Length of employment _____

Job description _____

Were you injured at work?_____

Present Illness

Describe the problem which brings you here: _____

_____

_____

_____

_____

What is your average pain level per month? no pain worst pain imaginable

0 1 2 3 4 5 6 7 8 9 10

What makes it better?_____

What makes it worse?_____

What test have you had done (include when and where): MRI _____ CAT scan_____

Myelogram_____ Bone Scan _____ X-rays _____

MEDI-PRINT SOU150-012

Name: _____

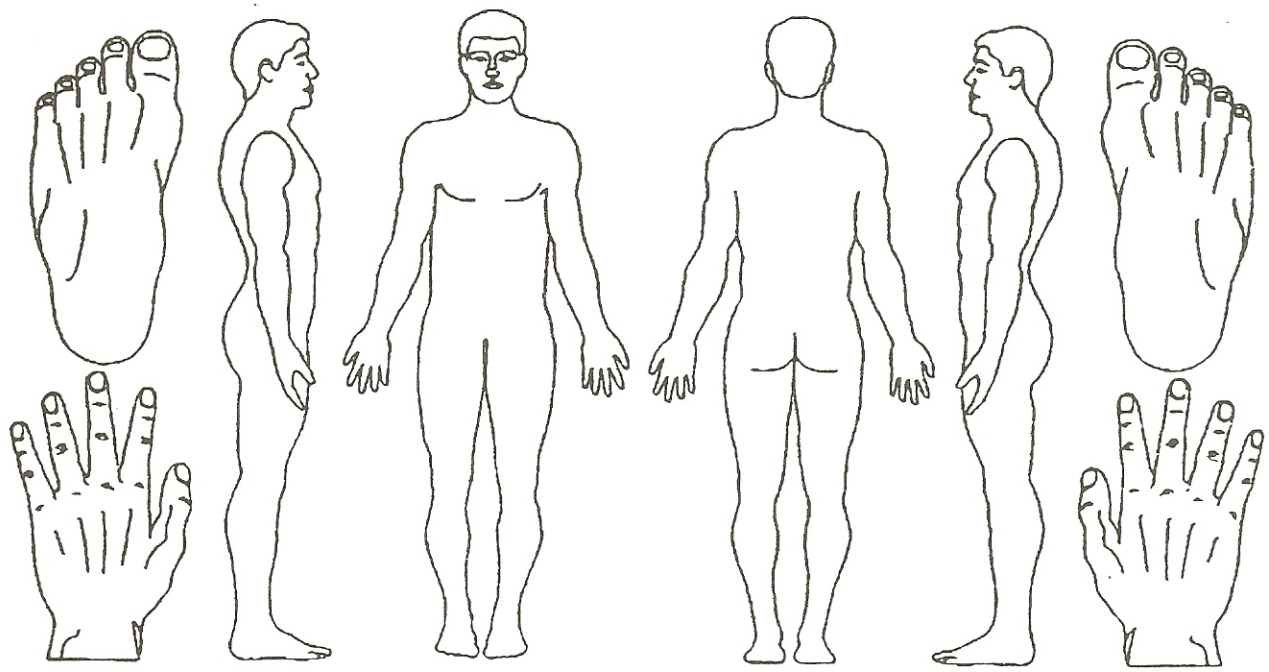
Do you presently smoke cigarettes or use tobacco in any form? ☐ Yes ☐ No

If no, have you ever smoked cigarettes or used tobacco in any form? ☐ Yes ☐ No

How many packs do (did) you smoke in a day? For how many years?

Pain Assessment

On the diagram below, shade the area(s) where you feel pain. Place an "X" on the area(s) that hurt the most.



Please fill in the lines below with pain treatments or medications you are receiving now, or have received in the past. (For example: pain medications, physical therapy, surgery, TENS, etc.)

Then circle the number next to the treatment to signify the amount of pain relief that treatment is or has provided.

Treatment or Medication	No Relief									Complete Relief
_____	1	2	3	4	5	6	7	8	9	10
_____	1	2	3	4	5	6	7	8	9	10
_____	1	2	3	4	5	6	7	8	9	10
_____	1	2	3	4	5	6	7	8	9	10
_____	1	2	3	4	5	6	7	8	9	10
_____	1	2	3	4	5	6	7	8	9	10