Dr. David H. Segal, M.D.

Eastern Iowa Brain and Spine Surgery, PLLC

Insurance ________________________________

Workers Compensation ☐Yes ☐No

Are you on disability? ☐Yes ☐No

MEDICAL INFORMATION

Patient Full Name (First/Middle/Last):____DOB: ____/_____/____________
Address:____Phone Number: ________________
Email Address:_______________________________ Phone Number: ________________________ Gender: Male / Female
Family Physician: ______________________________ Location:____
Referring Physician:______________________________Location: ____
Race: _______________ Ethnicity: _________________ Language: _________________ Religion: _________________

Treatment With any of the following providers within the last 2 years

Physical Therapist ☐ Name: _________________________Location: ______________________

Chiropractor ☐ Name: _________________________Location: ______________________

Radiology Services (X-Rays, Ultrasound, CT Scan, MRI) Location: ______________________

Cardiology, Pulmonology, Oncology Do you see any of these or any other specialist on a regular basis? ☐ Yes ☐ No

Cardiologist: __________________________Location: __________________

Have you ever had an abnormal EKG? ☐Yes ☐No If yes, When ___________________. Do you have a Pacemaker? ☐ Yes ☐ No

Pulmonologist: _________________________ Location: __________________

Oncologist:__________________________Location:__________________

Basic Medical Information (Please check all that apply to you)

Do you have high blood pressure? ☐Yes ☐ No Are you currently taking any medication to control your blood pressure? ☐ Yes ☐ No

Are you Diabetic? ☐ Yes ☐ No *Insulin Controlled* ☐ *Oral Medication* ☐ *Diet Controlled* ☐

Are you claustrophobic? ☐ Yes ☐ No Do you have any metal implants? ☐ Yes ☐No If yes, where? _________________

Do you have any stents Cardiac or Urinary? ☐ Yes ☐No Have you ever worked with metal? ☐ Yes ☐ No

Other past medical history: ____

Allergies

Are you allergic to LATEX? ☐ Yes ☐ No

Have you ever had any problems with radiology contrasts dyes? ☐ Yes ☐ No Are you allergic to shellfish? ☐ Yes ☐ No

Have you ever had any problems with Anesthesia? ☐ Yes ☐ No If so, please state what happened? _________________________

Please list any medication allergies and reaction:

____
____
____

Social History Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed Children ☐ Yes ☐ No

Employment: Place and nature of employment? ____

Smoking ☐Yes ☐No If yes, how many packs per day for how many years? ___/___If past smoker, when did you start and stop?

_______________. Alcohol use? ☐Yes ☐ No Daily use? ☐Yes ☐ No How often? <1, 2, 3, 4, >5 drinks per week?

Recreational drug use? ☐Yes ☐No If yes, what type and how often? ______________________________HIV/AIDS? Yes ☐ No☐

Surgical and Procedure History (Please list in detail below) Epidural/Facet injections? When, where and by whom?________________
____

Please list any brain, neck, or back surgery. Please list date, location, and surgeon.
Also list any other procedures? Please list date, location, and surgeon.

Please shade the areas of your pain in the diagram to the left.

Please Rate your pain by circling the number on the pain scale which describes your pain.

No Pain - - - - - - - - - - - - - - - - - Worst Pain Imaginable

0 1 2 3 4 5 6 7 8 9 10

Location and Radiation of Pain

Please indicate with a "P" on the diagram to the left where the pain is felt:

Describe your pain.

Sharp☐ Dull☐ Spasm☐ Cramping☐ Shooting❑ Aching❑ Burning❑

Do you have headaches associated with your neck pain? If so, where? ___________________

Changes since onset of symptoms (check all that apply)

☐Bowel incontinence ☐Bowel retention ☐Bladder incontinence ☐Bladder retention

☐Weakness in Arms __Right __ Left ☐Weakness in Legs __Right __ Left

☐Balance Problems

DO THE FOLLOWING ACTIONS RELIEVE OR WORSEN YOUR PAIN

Walking	☐Relieve	☐Worsen
Sitting	☐Relieve	☐Worsen
Standing	☐Relieve	☐Worsen
Lying down	☐Relieve	☐Worsen
Lifting	☐Relieve	☐Worsen
Bending	☐Relieve	☐Worsen
Resting	☐Relieve	☐Worsen

Coughing/Deep Breathing/Sneezing	☐Worsen
Pushing	☐Worsen
Pulling	☐Worsen
Straining at stool	☐Worsen
Neck Movement	☐Worsen
Overhead Reaching	☐Worsen
Twisting	☐Worsen

Does your pain spread? Where?

____

____

What brings on your pain, and what caused them (if known)?

____

____

Is your pain continuous or does it come and go?

____

____

Do you experience numbness? Where?

____

____

Do you experience tingling? Where?

____

____

Please list family history of father, mother, and siblings. Include major illness, heart disease, diabetes, cancer, etc.

____

____

Current Medication List

Pharmacy: ____

Medication Name	Dosage	Frequency

Please mark all that apply to you.

Eyes	Past	Now
Eye Glasses or Contacts		
Double or Blurred Vision		
Ears, Nose, and Throat/Mouth		
Hearing Aids		
Ringing in Ears		
Balance Disturbance, i.e. Vertigo, Spinning		
Hearing Loss		
Integumentary		
Skin Disease		
Skin Cancer		
MRSA		
Other		
Cardiovascular		
Heart Surgery(Please Specify)		
Heart Attack		
Coronary Artery Disease		
Chest Pain/Angina		
High Blood Pressure		
Irregular Pulse(Arrhythmia)		
Heart Murmur		
High Cholesterol		
Other		
Respiratory		
Asthma		
Chronic Cough		
Emphysema		
COPD		
Shortness of Breath		
Lung Cancer		
Sleep Apnea/ Use of CPAP		
Other		
Gastrointestinal		
Nausea		
Vomiting		
Bowel Retention		
Incontinence		
Colon Cancer		
IBD		
Neurological		
Fainting Spells or "Blacking Out"		
Seizures		
Memory Problems		
Disorientation		
Difficulty with Your Speech		
Inability to Concentrate		
Migraines		
Headaches		
Stroke		
Other		

	Past	Now
Genitourinary		
Kidney Disease		
Bladder Retention		
Kidney Stones		
Incontinence		
Prostate Cancer		
Uterine or Cervical Cancer		
Other		
Musculoskeletal		
Back Pain		
Arm or Leg Pain		
Joint Pain or Swelling		
Difficulty with Arm/Leg Coordination		
Hip Replacement R L		
Knee Replacement R L		
Carpal Tunnel		
Osteopenia		
Osteoporosis		
Other		
Psychiatric		
Anxiety		
Depression		
Other Psychiatric Disorders		
Endocrine		
Diabetes		
Thyroid Disease		
Liver Disease		
Jaundice		
Other		
Hematologic/ Lymphatic		
Anemia		
Hemophilia		
Bleeding Tendencies		
Other		
Immunologic		
Fibromyalgia		
Lupus		
Multiple Sclerosis		
Rheumatoid Arthritis		
Other		
Constitutional		
Sudden Weight ☐Loss/ ☐Gain (Amount)		
Weakness(Location)		
Headaches		
Excessive Fatigue		
Fever		
Chills		
Night Sweats		

The above information is correct to the best of my knowledge.

Name:__________________________DOB: ____________Signature: ________________________________Date: ______________