Boston Spine & Scoliosis

Reducing the trauma of Spine Surgery ®

Minimally Invasive Surgery of Cervical, Thoracic, and Lumbar Spine, Board Certified

Name: _____

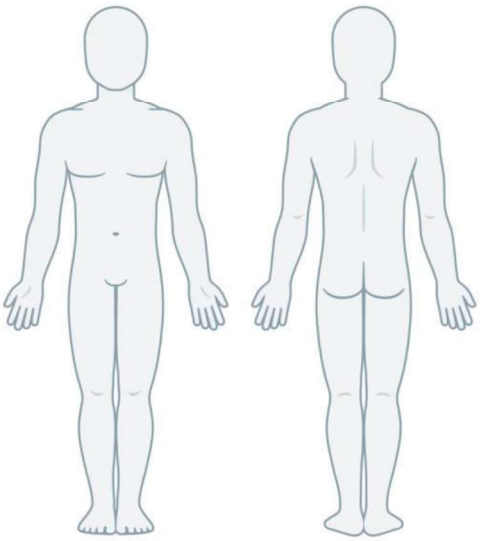
Date of Birth: _____ Phone Number: _____

Address: _____

Primary Care Physician: _____

Spine History

Please use the diagram below to label where your *current* pain is located:



How would you describe your pain?

____ Dull/Aching
____ Numbness/Tingling
____ Sharp/Shooting
____ Throbbing
____ Burning
____ Electric
____ Constant (all the time)
____ Intermittent (happens sometimes)

Rate your pain on a scale of 0-10, where 0 is no pain and 10 would send you to the Emergency Room (if your pain fluctuates, please provide the range of pain):

0 1 2 3 4 5 6 7 8 9 10

Have you had any treatment for the reason you are here about today? ____ Yes ____ No

If yes, please list below when and where *most recent* treatment was completed:

Physical Therapy: _____

Injections: _____

Pain Medications: _____

Surgery: _____

If your PCP is part of MassGeneral Brigham, please skip this section and continue to page 3.

If your PCP is NOT part of MassGeneral Brigham, please list any medical conditions you are currently being treated for, medications you are prescribed (with the dosing instructions), and ordering provider, or provide us with a list to scan into your chart:

Medication Name/Dose	Ordering Provider	Condition Being Treated

Do you have any allergies to medications? ____ Yes ____ No

If yes, which ones? _____

Social History

Do you drink alcohol? ____ Yes ____ No

If yes, how many drinks (on average), do you consume per week? _____

Do you currently smoke, vape, or use smokeless tobacco products? ____ Yes ____ No

If you are currently, which products? _____

How long have you been taking these products? _____

Do you use any types drugs that are not prescribed by a physician? ____ Yes ____ No

If yes, how many times (on average), do you use them per week? _____

Have you ever had any problems with addiction to prescription or nonprescription medications?

____ Yes ____ No