Northeast Georgia Physicians Group Neurosurgery and Interventional Pain Medicine

New Patient Paperwork

DATE:_____ NAME:_____ DOB:___/___/___ AGE:____

What problem are we seeing you for? _____

How long have you had this problem? _____

Who referred you?_____ Primary Care Physician: _____

Allergies? Yes No If yes, please list allergies and reactions:_____

PAST MEDICAL HISTORY (Circle any of the following conditions you have been diagnosed with):

Headaches	High Blood Pressure	Congestive Heart Failure	Anemia
Implanted Devices	Low Blood Pressure	Stomach Ulcers	Epilepsy
Stroke	Syncope	Diabetes	Arthritis
TIA	High Cholesterol	Low Blood Sugar	Fibromyalgia
Carotid Artery Disease	Thyroid Disease	Liver Disease	Psychiatric Disorder
Coronary Artery Disease	Asthma	Hepatitis	Anxiety
Heart Attack	Emphysema/COPD	Kidney Stones	Depression
Abnormal Heart Rhythm	Cancer	Kidney Disease	Claustrophobia

Other:_____

PAST SURGICAL HISTORY (Circle any of the following surgeries you have undergone):

Back Surgery	Carotid Surgery	Carpal Tunnel Repair	Gall Bladder
Neck Surgery	Cardiac Stent	Hysterectomy	Gastric Bypass
Brain Surgery	Pacemaker	Appendectomy	

Other:_____

SOCIAL HISTORY:

Alcohol Use: Yes No Frequency:_____

Tobacco Products: Current Former Never E-cigarettes

Currently working? Yes No Occupation:_____

Disability? Yes No Pending Seeking

Caffeine Beverages per day? _____

Under Stress? Yes No

Marital Status: _____

FAMILY HISTORY: Do any of your blood relatives have or have they ever had any of these conditions? Please list relationship to affected individual(s):

Heart Disease _____	Kidney Disease _____	Psychiatric History _____
Hypertension _____	Neuropathy _____	Drug Abuse _____
Stroke _____	Seizure Disorder _____	Parkinson's Disease _____
Back Surgery _____	Diabetes _____	Arthritis _____
Headaches _____	Brain Aneurysm _____	Trembling _____
Cancer _____		

REVIEW OF SYSTEMS (Circle any of the following symptoms you have experienced in the past 6 months):

Constitutional

Activity change

Appetite change

Fatigue

Fever

Unexpected weight change

HENT

Congestion

Ear pain

Hearing loss

Nosebleeds

Runny nose

Sinus pain

Sore throat

Ringing in the ears

Difficulty swallowing

Voice change

Eyes

Eye pain

Eye redness

Sensitivity to light

Visual disturbance

Respiratory

Chest tightness

Cough

Shortness of breath

Cardiovascular

Chest pain

Leg swelling

Palpitations

Gastrointestinal

Abdominal distention

Abdominal pain

Constipation

Diarrhea

Nausea

Vomiting

Endocrine

Cold intolerance

Heat Intolerance

Genitourinary

Large volume of urine

Painful urination

Urinary Frequency

Musculoskeletal

Joint pain

Back pain

Difficulty Walking

Joint swelling

Muscle pain

Neck pain

Skin

Color change

Rash

Allergies/Immune System

Food allergies

Immuno-compromised

Neurological

Dizziness

Headaches

Light-headedness

Numbness

Seizures

Speech difficulty

Syncope

Tremors

Weakness

Hematologic

Bruises/bleeds easily

Psychiatric

Agitation

Behavior problem

Confusion

Decreased concentration

Persistent bad mood

Hallucinations

Nervous/anxious

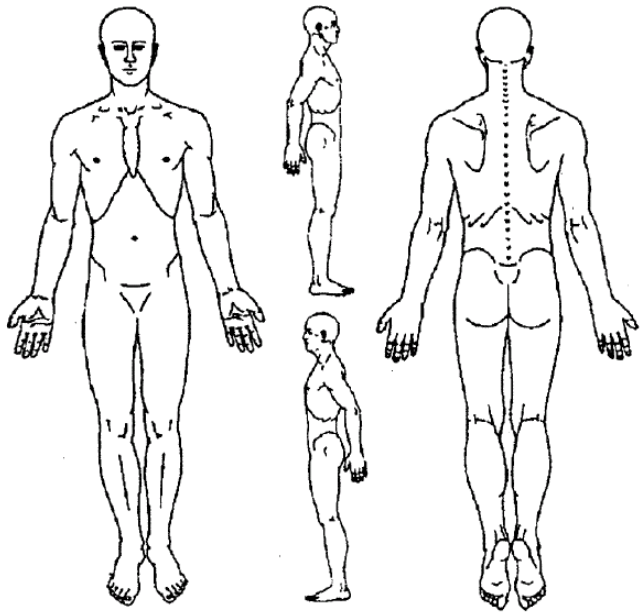
Sleep disturbance

Northeast Georgia Physicians Group Pain Survey

Name:_____ **Date:**_____

Location: In what part of your body is your pain the worst?_____

Please mark the area(s) of injury or discomfort on the chart below:



Describe the quality and character of your pain. (Check all that apply)

Aching Burning Cold Electric Shock Dull Hot/Flushed Numb Tingling Stabbing
Sharp Pins & Needles Throbbing Other (describe):_____

Rate the severity of your pain *at its worst* on this scale (1 = mild, 10 = worst pain of your life):

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

Radiation/Referral Pattern: Does your pain travel to other locations? Yes No If yes, where?_____

Describe the frequency of your pain. Daily Weekly Monthly Constant Infrequent/episodic/irregular

Timing: At what time of day (or night) is the pain at its worst?_____

Aggravating Factors: What worsens the pain?_____

Alleviating Factors: What makes the pain better?_____

Activity: Are you exercising, walking, stretching, etc? _____

How Many Hours of Sleep do you average per night?_____ Would you consider this quality sleep? Yes No

How would you describe your mood? Irritable Sad Happy most of the time Other:_____

Are you currently working? (Circle one) Full-Time Part-Time Not Currently Working

Current Medications

Name:_____ **Date of Birth:**_____

Retail Pharmacy:_____ **Phone:**_____

Mail-in Pharmacy:_____

Please list all current medications, including dosage and how many times per day you take each medication.

MEDICATION	DOSE	TIMES PER DAY
Example: Tramadol	**50 mg**	**Twice A Day**