

OOA Acct# _____

Staff Only:
 Height _____
 Weight _____
 BP _____
 Pulse _____

Olympia Orthopaedic Neurosurgery
 Dr. Ryan J. Halpin
PATIENT INFORMATION SHEET

Date: _____

_____ Male _____ Female
 Patient Name Date of Birth Age

Right Handed
 Left Handed
 (Please mark one)

_____ Referring Physician

_____ Primary Care Physician

Briefly describe your current symptoms:

When did your symptoms begin? _____

Any injury or trauma related to the onset of your symptoms? _____

Please rate your pain on a scale of 1 to 10, with 1 being no pain and 10 being the most severe pain imaginable:
 (Please circle your rate of pain)

Today: least	1	2	3	4	5	6	7	8	9	10	worst
Least (yet):	1	2	3	4	5	6	7	8	9	10	
Worst (yet):	1	2	3	4	5	6	7	8	9	10	

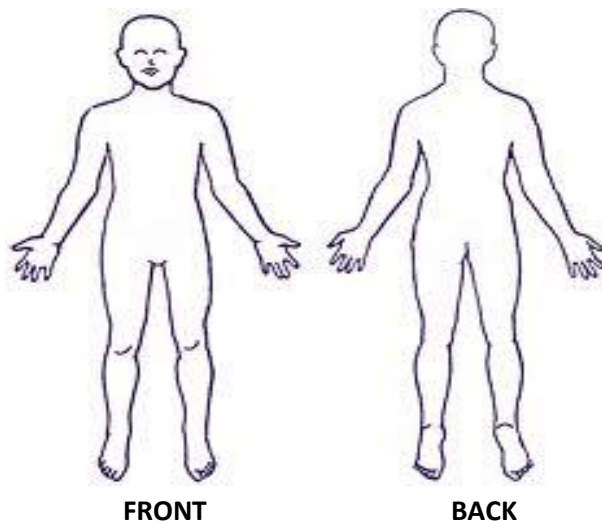
How would you describe your pain? (Please circle all that apply)

Sharp **Burning** **Dull** **Aching** **Cramping** **Stabbing** **Electric Shock**

Do you have **Numbness?** **Y** **N** **Tingling?** **Y** **N** **Weakness?** **Y** **N**

Use the letter symbols listed below and mark them where you are experiencing your sensations:

Ache: **AAAA** Numbness: **NNNN** Burning: **BBBB** Stabbing: **SSSS** Tingling: **TTTT**



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PATIENT INFORMATION SHEET (continued)

What makes your symptoms better? _____

What makes them worse? (Please circle all that apply)

- | | | | |
|-------------------------------|------------------|-----------------|-------------------|
| Bending forward | Bending backward | Twisting | Coughing/Sneezing |
| Standing from seated position | Walking | Climbing stairs | |

Have you had spine surgery before? **Y** **N**
If yes, please describe: _____

What **Non-surgical** treatments have you tried in the past? (Please circle all that apply)

- | | | | |
|--------------------------|---------------------------|-----------------------------|-------------|
| Physical Therapy | Traction | Epidural Steroid Injections | Nerve Block |
| Trigger Point Injections | Acupuncture | Yoga/Pilates | |
| Aquatic (Water) Therapy | Tens Unit | Massage & Ultrasound | |
| Physiatrist Physician | Pain Management Physician | Chiropractor | |

Have you ever had a bone mineral density scan (DEXA scan)? **Y** **N**

Past Medical History: (Please check any current or past problems)

- | | | |
|---|---|--|
| <input type="checkbox"/> Depression
<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Liver Abnormality
<input type="checkbox"/> Asthma
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Blood clot or Deep Venous Thrombosis (DVT) | <input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Anemia
<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Cancer
<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Kidney/Bladder problems
<input type="checkbox"/> Blood Abnormality | <input type="checkbox"/> Heart Disease/Attack
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> HIV or exposure
<input type="checkbox"/> Diabetes year onset _____
<input type="checkbox"/> Stroke
<input type="checkbox"/> Seizures
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Other |
|---|---|--|

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PATIENT INFORMATION SHEET (continued)

Surgery History:

Surgery Name	Surgery Date	Location where performed

Have you had surgical complications? **Y** **N**

If yes, please describe: _____

Current Medications: **Please include all prescription, over the counter, herbal supplements and vitamins you are taking**

Name of Medication	Reason	Dose	Frequency

Are you taking blood thinners? **Y** **N**

If yes, please mark which one(s): Coumadin Aspirin Plavix NSAIDs (Ibuprofen, Motrin, Aleve, Naprosyn, etc.)

Drug Allergies: **Please include reaction to medications**

Medication you are Allergic to	Reaction

Are you allergic to any of the following?

- | | |
|---|--|
| <input type="checkbox"/> Latex
<input type="checkbox"/> Tape/Adhesive
<input type="checkbox"/> Iodine | <input type="checkbox"/> Soap
<input type="checkbox"/> X ray contrast
<input type="checkbox"/> Shellfish |
|---|--|

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PATIENT INFORMATION SHEET (continued)

Family History: Please indicate medical conditions (Cancer, Diabetes, Heart Disease, other conditions)

Relationship (Mother, Father, Siblings, Children)	Medical Condition	Age (at death is deceased)

Social History:

Are you currently: (Please circle your status)

Married
 Single
 Separated
 Divorced
 Widowed
 Domestic Partner

Are you currently employed? **Y** **N**

If yes, occupation: _____ If no, when was the last time you were employed? _____

Do you use tobacco? **Y** **N**

If yes, do you:

Smoke Cigarettes? How many per day? _____ Years of use? _____

Smoke Cigar or Pipe? How many per day? _____ Years of use? _____

Chew Tobacco? How many cans per week? _____ Years of use? _____

Are you a **former** tobacco user? **Y** **N**

If yes, when did you quit? _____

Have you ever used recreational/non-medical drugs? **Y** **N**

If yes, type: _____

Do you drink alcohol? **Y** **N**

If yes, how many drinks a week (on average)? _____

Review of Systems: Please mark if you are experiencing or currently have any of the following:

Psychiatric

- Depression
- Bipolar Disorder
- Mood Swings
- Personality Changes

Ophthalmologic

- Glasses
- Blurry Vision
- Double Vision
- Loss of Vision
- Dry Eyes
- Other _____

ENT

- Difficulty Hearing
 - Ringing in Ears
 - Sinus Disease
 - Snoring
- Pulmonary**
- Shortness of Breath
 - Asthma/Wheezing
 - Cough
 - Bloody Cough/Sputum

Infectious Disease

- Fever
- Chills
- Sweats
- Recent Infections
- Hepatitis

Hematologic

- Anemia
- Low Platelets
- Bleeding Disorder
- Other _____

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PATIENT INFORMATION SHEET (continued)

Review of Systems (continued):

Please mark if you are experiencing or currently have any of the following:

- | | | |
|---|--|---|
| <p>Gastrointestinal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn <input type="checkbox"/> Stomach Ulcer <input type="checkbox"/> Bloody Stool <input type="checkbox"/> Black Tarry Stool <input type="checkbox"/> Bowel Incontinence <p>Musculoskeletal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Painful Joints <input type="checkbox"/> Swollen Joints <input type="checkbox"/> Neck Pain <input type="checkbox"/> Back Pain <input type="checkbox"/> Generalized Weakness <input type="checkbox"/> Gout <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Osteopenia | <p>Endocrine</p> <ul style="list-style-type: none"> <input type="checkbox"/> High Thyroid <input type="checkbox"/> Low Thyroid <input type="checkbox"/> Sexual Dysfunction <input type="checkbox"/> Menstrual Difficulty <input type="checkbox"/> Diabetes <input type="checkbox"/> Weight Loss <p>Genitourinary</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bladder Incontinence <input type="checkbox"/> Bloody Urine <input type="checkbox"/> Foul Smelling Urine <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Erectile Dysfunction <p>Cardiovascular</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Circulation Problems in your Arms or Legs <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Other _____ | <p>Dermatologic</p> <ul style="list-style-type: none"> <input type="checkbox"/> Skin Rashes <input type="checkbox"/> Skin Cancer <p>Neurologic</p> <ul style="list-style-type: none"> <input type="checkbox"/> Impaired Thinking <input type="checkbox"/> Memory Loss <input type="checkbox"/> Difficulty with Taste/Smell <input type="checkbox"/> Difficulty Walking <input type="checkbox"/> Falling Down <input type="checkbox"/> Tremors/Shaking <input type="checkbox"/> Spasticity <input type="checkbox"/> Poor Coordination <input type="checkbox"/> Seizure <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Speech Difficulty <input type="checkbox"/> Blackouts/Fainting <input type="checkbox"/> Meningitis <input type="checkbox"/> Encephalitis <input type="checkbox"/> Swallowing Difficulty <input type="checkbox"/> Decreased Attention |
|---|--|---|

I attest all information I have provided is true and correct to the best of my knowledge

Patient/Responsible Party Signature

Date

Physician Signature

Date