JAMES M. LEIPZIG, M.D., F.A.C.S.
SPINAL SURGERY

Medical History

Personal Information

Date _________

Name_________________________________ Height________Weight _________

Birthdate ____________Age _____Right or left handed: Right ____Left ____

Occupation____________________________

Married ___ Single___Widowed___ Divorced___

Referring Physician________________________ Primary Physician __________________

Physical Symptoms

List your major symptoms in order of importance
1. ____

2. ____

3. ____

When did the problem start or injury occur? ___________________________________

How? ____

If involved in an auto accident, are you in litigation? Yes______ No______

Is the Pain:
Constant ___Intermittent ___Infrequent ___Occasional ___ (more than 25% of the time?)

Pain severity now on a scale of 1 (very little) to 10 (most severe) ___________

Describe your treatment to date:

____

____

____

Past Medical History

Previous Surgery ____

Medical Illnesses ____

Medications ____

Drug Allergies ____

Family Illness ____

Recreational Activities ____

Do you use tobacco products? No____Yes____
If yes, what type and amount per day? ____

Do you Drink Alcoholic Beverages? No ___Yes ____
If yes, amount per day____

Please briefly describe how your back or neck problem has interfered with your life:

____

____

____

If you have been incapacitated and unable to work, please give dates of disability:
From__________ to __________

If your symptoms are due to a specific injury, did you have a prior history of back or neck pain? No _____Yes_____

Briefly Describe:
____

____

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