MedStar Georgetown University Hospital

Department of Neurosurgery
Brain and Spine Surgery
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Clinic Flow Sheet

Patient Name: _____ DOB: _____ Date: _____

Today's appointment is a: New Patient Return Visit Post Op: Surgery Date: _____

Circle any recent diagnostic imaging or conservative treatment(s): Where Completed? _____

MRI CT Scan X-Ray Injections Physical Therapy Steroids

What is your Height: _____ Weight: _____

Where are you having problems? _____

How long ago did this problem start? _____ Days _____ Weeks _____ Months _____ Years

How frequently do you experience this problem? constantly daily weekly monthly yearly

How would you describe this problem? Dull/achy sharp numb tingling burning other _____

What makes your problem worse? lifting bending sitting walking standing other_____

Does your problem radiate? Yes / No If yes: Right / Left / Bilateral

New allergies: Yes / No If yes: _____

Changes to your medications: Yes / No If yes: _____

Smoking History: Yes / No If yes: Current / Former

Please circle the number below that best describes your current level of pain:

0	No Pain	4	Moderate	8	Intense
1	Minimal	5	Distracting	9	Severe
2	Mild	6	Distressing	10	Bed Ridden
3	Uncomfortable	7	Unmanageable		

Authorization to Discuss Protected Health Information (PHI)

Please list anyone below who you authorize our practice, MedStar Georgetown University Hospital Department of Neurosurgery, to communicate with regarding your care with our practice.

Name of Individual(s) _____