PREMIER PAIN & SPINE
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Schaumburg, IL 60173
(847) 519-4701

PRE-EVALUATION QUESTIONNAIRE

Today's Date

Name

First | Last | MI | Phone #

O Male O Female

Gender (Select One) | Height | Weight | Birthdate | Age

Primary Insurance | Patient ID / Member ID

Please answer the following questions to the best of your ability.

Mark Circle if Answer is Yes

- O Are you pregnant?
- O Do you have a pacemaker or defibrillator?
- O Do you have a spinal cord stimulator?
- O Do you have a pain or insulin pump?
- O Do you have any electrical or metal implants or sensors of any kind?

SECTION 1 **Regarding your health**

[1A] Have you ever been diagnosed with any of the following cardiovascular disease or symptoms?

- O Peripheral Vascular Disease *(PVD - Circulation disorders in blood vessels)?*
- O Do you have or have you had chronic ulcer(s)? (Stage II, III, or IV).
- O Raynaud's Syndrome *(discoloration of fingers and/or toes whenexposed to changes in temperature (cold or hot) or emotional event)*?
- O Do you often experience abdominal pain?
- O Do you have, or have you had, gangrene?
- O Embolism of the upper limb/limbs (Artery obstruction in the arms)?
- O Beurger's disease *(Inflammation or clotting in blood vessels in hands or feet)?*
- O Do you have hypertension *(high blood pressure)*?

[1B] Have you ever been diagnosed with any of the following cardiovascular conditions or symptoms?

- O Do you ever have pain in your arms and/or legs?
- O Pain in your neck often (Cervicalgia)?
- O Hypotension (very low blood pressure)?
- O Do your hands and feet get cold easily?
- O E.S.R.D. (End stage renal disease)?
- O Dizzy and or light headed when you stand up?
- O Bells' Palsy
- O Pain in your lower back (Lumbago)?
- Pain in your upper back (Thoracic Pain)?
- O Rapid Heart Rate (Tachycardia)?
- O Do you ever notice a tingling/numbness feeling in your fingers, arms, legs or feet?
- O Often experience a lack of coordination when active (Ataxia)?

SECTION 2 **Regarding your personal and family health history.**

- O Do you smoke or have you ever smoked?
- O Do you have diabetes?
- O Do you have high cholesterol?
- O Do you have a history of CVA or TIA (Stroke or mini stroke)?
- O Has anyone in your immediate family (blood relatives) been diagnosed with cardiovascular disease (CVD), or have had a heart attack?
- O Has anyone in your immediate family (blood relatives) passed away from Sudden Cardiac Death Syndrome (SCD)?

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Patient Signature | Physician Signature