T. Craig Derian, MD, PLLC
Adult Spine Surgery

Name _____ **Date** _____ **MR** _____

We must have the following information about all the medications you take, both prescription and over the counter medications such as herbal supplements, pain relievers such as Tylenol, Advil, Aleve, etc.; vitamins, minerals, or any other types of dietary supplements (protein powders, yeasts, etc.) you take to help keep you well.

**** Please have this form filled out before you arrive for your appointment ****

Height _____ **Weight** _____

Name of Medication	Dose or Strength	Times per Day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Please note any drug allergies or sensitivities

Name of Medication	Reaction
1.	
2.	
3.	
4.	
5.	

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Visual Analog Scale

Patient Name _____ **MedRec Number** _____	**Date** _____

Place an "X" in the box below which best describes your pain level.

Back

No Pain	1	2	3	4	5	6	7	8	9	10	Worst Pain

Left Leg

No Pain	1	2	3	4	5	6	7	8	9	10	Worst Pain

Right Leg

No Pain	1	2	3	4	5	6	7	8	9	10	Worst Pain

Patient Signature _____ **Date** _____