MEDICAL HISTORY

PLEASE COMPLETE THIS MEDICAL HISTORY FORM AS THROUGHLY AND ACCURATELY AS POSSIBLE. IF THE QUESTION DOES NOT APPLY TO YOU, PLEASE WRITE N/A IN THAT BLANK. IF YOU DO NOT UNDERSTAND A QUESTION, PLEASE ASK FOR ASSISTANCE. TURN OVER AND COMPLETE SIDE 2.

Name	**Age**	**Height**	**Weight**	**Dominant Hand** ❑ Right ❑ Left	**Marital Status** ❑ Married ❑ Single ❑ Divorced ❑ Widowed	**# of Children**

Major Illnesses	❑ None ❑ High Blood Pressure ❑ Diabetes ❑ Heart Disease ❑ Lung ❑ Cancer ❑ Other (specify)
Current Medications	❑ None ❑ Blood Thinners
Previous Surgeries (Type and Date)	❑ None
Allergies	❑ None ❑ Penicillin ❑ Sulfa ❑ Latex ❑ Other (specify)

Occupation	**Tobacco Type** ❑ None	**Tobacco Amount**	**Alcohol Amount** ❑ None	**Alcohol Frequency**

Family Medical History	**High Blood Pressure** ❑ Mother ❑ Father ❑ Sibling	**Heart Disease** ❑ Mother ❑ Father ❑ Sibling	**Diabetes** ❑ Mother ❑ Father ❑ Sibling	**Cancer** ❑ Mother ❑ Father ❑ Sibling

Review of Systems

General Information	❑ change in appetite ❑ weight gain ❑ weight loss ❑ fatigue ❑ chills ❑ fever ❑ other (specify)
Skin	❑ itching ❑ rash ❑ hives ❑ bruise easily ❑ psoriasis ❑ bleed easily ❑ skin cancer ❑ varicose veins ❑ skin discoloration ❑ other (specify)
Immune System	❑ seasonal allergies ❑ cancer ❑ other (specify) If Cancer, specify type _____
Ears, Nose, Mouth, Throat	❑ hearing problem ❑ ringing in ears ❑ discharge from ears ❑ nose bleeds ❑ other
Eyes	❑ wear glasses ❑ blindness ❑ cataracts ❑ glaucoma ❑ other (specify)
Respiratory	❑ asthma ❑ wheezing ❑ shortness of breath ❑ frequent coughing ❑ other (specify)
Cardiovascular	❑ high blood pressure ❑ heart attack ❑ chest pains ❑ blood clotting disorder ❑ other (specify)
Gastrointestinal	❑ frequent nausea ❑ indigestion ❑ heartburn ❑ vomiting ❑ diarrhea or constipation ❑ hemorrhoids ❑ blood in stools ❑ difficulty controlling bowels ❑ other (specify)
Genitourinary	❑ pain or burning with urination ❑ frequent urination ❑ blood in urine ❑ kidney stones ❑ difficulty controlling urine ❑ enlarged prostrate ❑ pelvic infection ❑ irregular periods ❑ painful periods ❑ post menopause ❑ pregnant ❑ other (specify)
Endocrine	❑ diabetes ❑ enlarged thyroid ❑ hyperthyroid ❑ hypothyroid ❑ steroid use ❑ other
Musculoskeletal	❑ difficulty walking ❑ arthritis ❑ deformities ❑ gout ❑ osteoporosis ❑ other
Neurologic	❑ frequent headaches ❑ seizures ❑ dizziness ❑ memory loss ❑ fainting ❑ paralysis ❑ stroke ❑ balance problems ❑ speech problems ❑ coordination problems ❑ numbness or tingling ❑ other (specify)
Psychiatric	❑ nervousness ❑ difficulty sleeping ❑ depression ❑ emotional problems ❑ other (specify)
Blood or Lymphatic	❑ anemia ❑ bruise easily ❑ swollen lymph nodes ❑ reaction to blood transfusion ❑ other (specify)
Please detail any other problems or concerns that you feel your doctor needs to be aware of	

Patient Signature _____ **Date** _____

Physician Signature _____

Please turn over and complete Spine History

SPINE HISTORY

Occupation	Date back / neck pain started	Current episode started
Did pain start? ❑ gradually ❑ suddenly	**How did it start?** ❑ Auto Accident ❑ Fall ❑ Lifting ❑ Bending ❑ Pulling ❑ Twisting ❑ Hit in Back ❑ Other	
Do you have arm pain ❑ Yes ❑ No	**Do you have leg pain?** ❑ Yes ❑ No	**When did arm / leg pain start**
Do you have numbness in arm? ❑ Yes ❑ No	**Do you have numbness in leg?** ❑ Yes ❑ No	**Do you have muscle weakness?** ❑ Yes ❑ No

List doctors you have consulted about your back/neck pain

1. _____ **3.** _____

2. _____ **4.** _____

Have you had any of the following for your back / neck?

	# of times	Dates	Doctor/Facility
Hospitalization	_____	_____	_____
MRI	_____	_____	_____
X-Rays	_____	_____	_____
CT Scan	_____	_____	_____
Myelogram	_____	_____	_____
EMG	_____	_____	_____
Bone Scan	_____	_____	_____
Discogram	_____	_____	_____

Have you returned to work ❑ Yes ❑ No | **If not presently working, date last worked**

Have you taken medication for this pain? ❑ Motrin ❑ Celebrex ❑ Naprosyn ❑ Clinoril ❑ Indocin ❑ Voltaren ❑ Cortisone (Steroids: Prednisone, Decadron or Medrol) ❑ Other _____

❑ Hydrocodone ❑ Other Narcotics _____

Duration medication attempted _____ **Did medication improve symptoms?** ❑ Yes ❑ No ❑ Temporarily

Have you taken any of these muscle relaxants? ❑ Flexeril ❑ Norflex ❑ Parafon Forte ❑ Robaxin ❑ Soma ❑ Valium ❑ Zanaflex ❑ Other _____

Have you had?

						Dates	Facility
Physical Therapy	❑ Yes	❑ No	❑ Better	❑ Worse	❑ No Change	_____	_____
Chiropractic	❑ Yes	❑ No	❑ Better	❑ Worse	❑ No Change	_____	_____
Home Exercise Program	❑ Yes	❑ No	❑ Better	❑ Worse	❑ No Change	_____	_____
Corset or Brace	❑ Yes	❑ No	❑ Better	❑ Worse	❑ No Change	_____	_____
Cortisone Injection	❑ Yes	❑ No	❑ Better	❑ Worse	❑ No Change	_____	_____
Back / Neck Surgery	❑ Yes	❑ No	❑ Better	❑ Worse	❑ No Change	_____	_____

Please check one

❑ Back pain is worse than leg pain ❑ Back pain equals leg pain ❑ Leg pain is worse than back pain

Please check the appropriate boxes. **My pain is:**

With cough or sneeze	❑ Better	❑ Worse	❑ No Different
With straining	❑ Better	❑ Worse	❑ No Different
Sitting	❑ Better	❑ Worse	❑ No Different
Bending forward to brush teeth	❑ Better	❑ Worse	❑ No Different
Walking up stairs	❑ Better	❑ Worse	❑ No Different
Walking down stairs	❑ Better	❑ Worse	❑ No Different
Lying flat on stomach	❑ Better	❑ Worse	❑ No Different
Lying on side with knees bent	❑ Better	❑ Worse	❑ No Different
Lying on back	❑ Better	❑ Worse	❑ No Different
Bending	❑ Better	❑ Worse	❑ No Different
Lifting	❑ Better	❑ Worse	❑ No Different
Standing	❑ Better	❑ Worse	❑ No Different

Which best describes the amount of pain you have daily

❑ No Pain ❑ Little Pain ❑ Moderate Pain ❑ Quite Bad Pain ❑ Very Bad Pain ❑ Unbearable Pain