Patient Medical History & Problems List

Name_____ Date of Birth _____Age_____

Social Security # _____ Referring Doctor_____ Height _____ Weight _____

Occupation_____ Employer_____

Marital Status _____

Drug Allergies (Please indicate by checking the boxes below)

□ **NO KNOWN DRUG ALLERGIES**

□ Local anesthetics (Novocain etc.) □ Penicillin □ Keflex □ Erythromycin □ Other antibiotics_____

□ Sulfa drugs □Aspirin □ Narcotics (codeine, morphine etc.) □ Other painkillers (Percocets, Oxycontin etc.)

□ Latex □ Eggs/ Yolk □ Sulfites □ Tetracycline □ Iodine/ Shellfish □ MSAIDs (Ibuprofen etc.)

Please specify any others: _____

Please specify type of reaction: _____

Social Habits

Alcohol- Do you use alcohol? _____ How much? _____/ week. If you quit, when? _____

Tobacco- Do you smoke or use tobacco products? _____ How much? _____/ day.

Numbers of Years using _____

Illicit Drugs- Do you use illicit drugs? _____

***Have you or your family member ever been diagnosed with a blood clot in a leg or a lung? _____ Yes _____No**

Are you under the care of a cardiologist: _____ Yes _____ No Name: _____

Contact Info: _____

Have you ever had problems with Anesthesia in the past?

If yes, please explain: _____

Medical Conditions: (please circle any of the listed medical conditions that you have been or are currently being treated for. Detail below.)

Neurologic Problems Migraines Seizures Stroke Carpal Tunnel High Blood Pressure Heart Attack Irregular Heart Beat Heart Murmur Kidney or Bladder Problems Gout Kidney Stones Diabetes Prostate Problems Thyroid Problems Hepatitis Cirrhosis Anemia Pneumonia Emphysema Tuberculosis Cancer Hiatal Hernia Rheumatoid Arthritis Asthma Pregnancy (include # of pregnancies and # of deliveries) Broken Bones Ligaments of Tendon Injury Joint Problem Ulcer Anxiety Depression **Other Condition Not Listed**: _____

Please list Surgeries/ Complications/ Diagnoses/ along with DATE:

Surgeries	**Year**	**Complication**
1.		
2.		
3.		
4.		
5.		

Medical Problems	**Year**	**Complications**
1.		
2.		
3.		
4.		
5.		

Family History

Is there a history of any of the following conditions in your family?

Please circle and state which family member is/ was effected. Date below:

Diabetes Heart Attack Cancer Kidney Problems Arthritis

Bleeding/ Clotting Problems Other Inherited Disease:

_____

_____

Review of System

Have you experienced any of the following in the **last few weeks or month?**

Please circle the complaints and detail below. If you have no complaints in category, please circle "NONE"

General:	fever chills swollen glands loss of memory weakness aches/ pains weight loss/ gain	NONE
Headaches:	Yes	NONE
Eyes:	double vision blurry vision eye pain	NONE
Ear/ Nose/ Throat:	ear pain hearing loss ringing in the ears nose bleeds sinus problems tooth pain hoarseness	NONE
Skin:	rashes changing moles change in skin color other lesions itchy skin	NONE
CV:	irregular heart beat palpitation chest pain cramping in legs feet always cold	NONE
Lungs:	cough cough up blood wheezing night sweats swollen ankles shortness of breath	NONE
GI:	poor appetite indigestion/heartburn nausea vomiting blood abdominal pain/ cramps	
	constipation change in bowel rectal bleeding	NONE
GU/GYN:	urinate at night more than once blood in urine burning or pain when urinating	
	Problem passing urine problem controlling urine	NONE
Neuro:	leg or arm weakness balance problems dizziness fainting spells speech problems	NONE
MS:	joint pains joint swelling loss of strength back pain	NONE
Hemo	abnormal bruising abnormal bleeding	NONE
Endocrine:	constant thirst most always cold too warm most of times very sluggish or tired	NONE

Spine History Form

Primary Care Doctor: _____

Who referred you here? _____

Name: _____ Date: _____

Age: _____ Birth date: _____ Sex: _____ Height: _____ Weight: _____

Occupation: _____

1. **Chief Complaint** (reason why you are here)

   _____

2. **History of present problem**:

   Date problem began: _____

   Is this a work- related of auto injury? _____

   Did problems begin following? A fall _____ lifting _____ work injury _____

   Where is the pain located? _____

   Is the pain better _____ same _____ worse _____ than when it started?

   Describe the quality of pain (e.g. burning, stabbing, throbbing)

   _____

   _____

   Is the pain? (Circle)

   Constant

   Constant but worse with activity

   Intermittent (comes and goes)

   Intermittent but worse with activity

   What makes the pain worse? (e.g. walking, bending, sneezing, coughing, sitting, standing)

   _____

   Is there a time of a day when it is worse? Morning _____ Evening _____ Night _____

   Does the pain wake you up at night? Yes _____ No _____

   Do you have? Fever/ Chills/ or unexplained weight loss? _____

   Do you have "pins and needles" in your feet/ hands? _____

Do you have numbness in your feet/ hands? Y N

Do you have weakness in your arms or legs? Y N

Do you have full control of your bowel and bladder? Y N

(Explain if NO): _____

Are you able to perform your usual activities of daily living? Y N

Have you had surgery for this problem? Y N

If so, describe date, surgeon & procedure:

_____

_____

Did surgery help? _____

Check any Studies You Have Had For Current Problem:

Diagnostic X-rays _____

MRI (magnetic resonance imaging) _____

CT (computed tomography) _____

Myelogram (X-ray w/ spinal inj.) _____

Discogram _____

Electromyogram (EMG) _____

Arthrogram/ sonogram _____

Check Any Treatment You Have Had For Current Problem:

		How long did you have treatment?
Physical Therapy	_____	_____
Home strengthening/ stretching	_____	_____
Home exercise	_____	_____
Acupuncture	_____	_____
Chiropractic	_____	_____
Epidural spine injections	_____	_____
Massage	_____	_____
Other (please explain)	_____	_____

Have any treatment ever made the pain better? _____ If yes, which treatment helped?

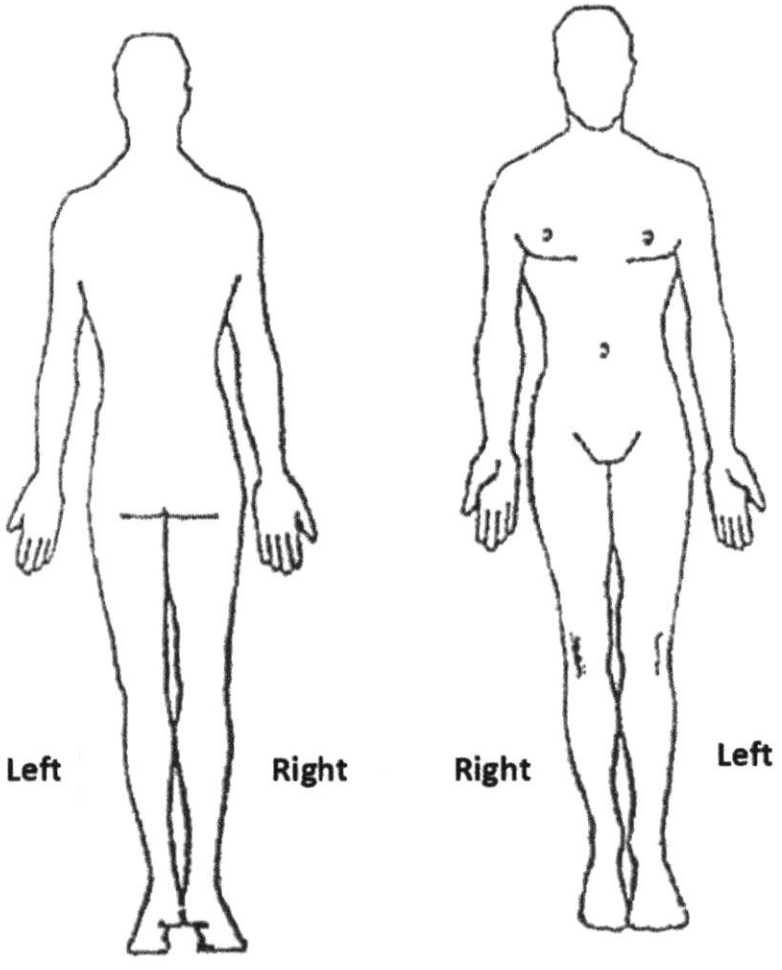
_____

_____

PAIN DESCRIPTION

Where is your pain right now?

Mark the areas on the body below where you feel the described sensations, using the appropriate symbols.
Mark the areas of radiation, including all affected areas.



Ache ^^^^^ ^^^^^

Numbness OOOO OOOO

Pins & Needles ■■■■ ■■■■

Burning XXXX XXXX

Radiating Pain ////// //////

HOW BAD IS YOUR PAIN RIGHT NOW? (PLEASE CIRCLE)

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

NO PAIN **INTERMEDIATE PAIN** **WORST PAIN**

HEIGHT:_____ **WEIGHT:**_____ **BLOOD PRESSURE (IF KNOWN):**_____/_____

NAME (PRINTED):_____ **DATE:**_____

17. MEDICATIONS: PLEASE LIST ALL MEDICATIONS AND VITAMINS YOU ARE CURRENTLY TAKING AND THE DAILY DOSAGE :

MEDICATION	DOSAGE	FREQUENCY

PATIENT CONSENT AND AUTHORIZATION

1. **Consent to Treatment**. I hereby authorize **{INSERT NAME}**., through its physicians and health care staff, to provide medical services to me, and I hereby consent to the performance of laboratory tests, diagnostic procedures, and other medical treatment as discussed with my health care provider. I also authorize **{INSERT NAME}**., to obtain outside medical and medication histories.

2. **Release of Information**. I hereby authorize **{INSERT NAME}**., to release and disclose all or any portion of my patient records to any person or entity which is or may be responsible for all or part of the charges for services rendered to me (including, but not limited to, insurers, employers and health care service plans) for the purposes of obtaining payment. I also authorize the release of patient information to other health care providers for purposes of diagnosis or treatment, and as may be required by law.

3. **Assignment of Benefits**. I hereby assign to **{INSERT NAME}**.,. and authorize payment directly to it of any and all health insurance or health plan benefits otherwise payable on my behalf or to me for services rendered. I understand and agree that I am financially responsible for any charges not paid by insurance benefits or otherwise not covered by this assignment and agree to pay the full cost of all such charges for services rendered.

4. **Health Care Service Plan Obligation**. I understand that **{INSERT NAME}**., participates on the panels of various health care service plans with which it contracts. If services rendered are found to be noncovered by a contracted health care service plan, or if I am not eligible to receive services by a contracted health care service plan, I agree to be individually obligated to pay the full cost of the services rendered to me by **{INSERT NAME}**.,

5. **Financial Agreement**. I hereby agree that I am individually obligated to pay all charges for services rendered to me that are not paid by insurance benefits or covered by a health care service plan (including, but not limited to, coinsurance, copayments and deductibles). I accept full financial responsibility for all such charges billed and guarantee to pay all such charges. All accounts are due and payable upon presentation of a statement. I understand that if any bill remains unpaid thirty (30) days after the statement date, interest will accrue at a rate of one percent (1%) per month on the unpaid balance. In the event that my account must be place with an attorney or collection agency to obtain payment, I further agree to pay all reasonable fees and collection expenses. I also agree that if my insurance plan pays my benefits directly to me, I will immediately send a check in the amount of the benefits paid to **{INSERT NAME}**.,

I hereby certify that I have read, understand and accept the above terms and conditions.

Patient Name (Print)	Patient Signature	Date

If patient is a minor or unable to consent

Name of Legal Representative	Signature of Legal Representative	Relationship to Patient	Date

Witness: _____ Date: _____