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Medical History Form - Spine

Name:______________________________ **Age:**_______ **Today's Date:**___________

Referred by:____
Primary Care Physician Name: ____
Address: ____
Phone: ______________________________**Fax:** _______________________________

Describe the problem that you want the doctor to address with you at this visit:

How would you describe your pain? **(Please check all that apply)**
__Burning __Aching __Pins & Needles __Electrical __Numbness
Other: ____

What other symptoms do you have? **(Please check all that apply)**
__Right Arm Weakness __Left Arm Weakness __Right Leg Weakness __Left Leg Weakness
__Right Hand Weakness __Left Hand Weakness __Right Foot Drop __Left Foot Drop
__Loss of Bladder Control __Difficulty Urinating __Difficulty Walking
__Loss of bowel control __Constipation __Falling down

What makes you feel Better? **(Please check all that apply)**
__Sitting __Standing __Laying Down __Bending Over
Other:____

What makes your symptoms Worse? **(Please check all that apply)**
__Sitting __Standing __Laying Down __Bending Over
Other:____

Do you associate a time of day with your symptoms being Worse? **(Please check all that apply)**
__Upon just getting out of bed __Midmorning __Afternoon __Evening

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Recent Treatment

The following questions pertain to therapies you have recently tried for your current problem.

What non-surgical therapies have you undergone?

Rate how effective each treatment was on a scale from 1-10 (Please check all that apply)

Physical Therapy		
Bracing		
Heating Pad		
Bedrest		
Chiropractor		
TENS stimulation		
Accupuncture		
Oral Steroids		

Which is your dominant hand? Right Left **Your height:_________Weight:________**

Please circle any of the following problems that pertain to you:

Weight loss/gain	Shortness of breath	Bowel/Bladder incontinence
Fatigue	Asthma	Erectile dysfunction
Skin Changes/rashes	Emphysema/Bronchitis	Muscle Weakness/spasm
Headache	Heart Disease	Loss of sensation/numbness
Vision changes	High Blood Pressure	Swelling of extremity
Hearing loss	Nausea/Vomiting	Diabetes
Dizziness	Diarrhea/Constipation	Depression/Anxiety
Bleeding Problems	Problems with anesthesia	Seizures

Family History

__Heart Disease __Hypertension __Diabetes __Stroke __Aneurysm __Epilepsy
__Spinal Problems __Cancer (List types):______________________________
__Other :____

Please list any previous hospitalizations and surgeries:

Date Problem Facility where treatment occurred

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Please list ALL of your current medications:

Drug Name	Dose

Allergies to medications: (please list any allergies to medications, foods, anesthesia reaction)

Name	Reaction

Social History

Your marital status: __Single __Married __Divorced __Widowed __Cohabitating
Employment status: __Retired __Employed __Homemaker __Student __Unemployed
On Disability: __Yes __No If yes, for what? ____
Current Occupation: ______________________ **Previous Occupation:** ____________________
Who lives with you? ______________________**If sick, who would help you?** _______________
Number of Children: _____ **Ages:** _______________________________________
Highest level of education: __Elementary __Junior High __High School __College __Graduate School
Do you exercise regularly? __Yes __No **Type:** _______________________________________
Do you have tattoos? __Yes __No If yes, professionally done? __Yes __No When? _________

Substance	Ever Used?	Current Use?	Amount per day/week	# Years Used	If stopped, when?
Tobacco	Y N	Y N			
Alcohol	Y N	Y N			

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