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 ❑ Diabetes ❑ Heart Disease ❑ Lung ❑ Cancer ❑ Other (specify)

Current Medications ❑ None

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	**Hypertension**	**Heart Disease**	**Diabetes**	**Cancer**
	❑ Mother ❑ Father ❑ Sibling	❑ Mother ❑ Father ❑ Sibling	❑ Mother ❑ Father ❑ Sibling	❑ Mother ❑ Father ❑ Sibling

Review of Systems

General Information	❑ change in appetite ❑ weight gain / 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)
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 ❑ venereal disease ❑ pelvic infection ❑ irregular periods ❑ painful periods ❑ post menopause ❑ pregnant ❑ vaginal discharge ❑ 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 ❑ considered suicide ❑ 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

Physician Signature ____ **Date** _____________________

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
Hospitalization	____________	________________	__________________
MRI	____________	________________	__________________
CT Scan	____________	________________	__________________
Myelogram	____________	________________	__________________
EMG	____________	________________	__________________
Bone Scan	____________	________________	__________________
Discogram	____________	________________	__________________

Have you returned to work ❑ Yes ❑ No | **If not presently working, when did you last work** / /

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

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

Have you had?

Physical Therapy	❑ Yes	❑ No	❑ Better	❑ Worse	❑ No Change
Chiropractic	❑ 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