



INNOVATIVE SPINE CARE

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www.GotSpinePain.com

(Please Print Clearly)

Patient Medical History

Name _____ DOB _____ Age _____ Date _____

Height: _____ WC _____ MVA (please circle) DOI/DOA: _____

What is the main reason you are here? _____

CURRENT MEDICATIONS (List all medications-use back of this sheet if you need more room)

MEDICATION	DOSAGE	#Per Day/Frequency	Reason for Taking (if known)

ARE YOU ALLERGIC TO ANY MEDICATION: YES NO If so, what? _____

PAST MEDICAL HISTORY- Check all that apply

<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bronchitis or Emphysema	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Hypo/Hyper Thyroid	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Blood Clots
<input type="checkbox"/> High Cholesterol		<input type="checkbox"/> History of Cancer	
		<input type="checkbox"/> type: _____	

PAST SURGICAL HISTORY- Check all that apply

<input type="checkbox"/> Appendix	<input type="checkbox"/> Prostate	<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Other: _____
<input type="checkbox"/> (Appendectomy)	<input type="checkbox"/> Breast Surgery	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> _____
<input type="checkbox"/> Gall Bladder	<input type="checkbox"/> Back Surgery	<input type="checkbox"/> Arthroscopy	<input type="checkbox"/> _____
<input type="checkbox"/> (Cholecystectomy)	<input type="checkbox"/> Total Joint		<input type="checkbox"/> _____
<input type="checkbox"/> Heart Bypass	<input type="checkbox"/> Replacement		<input type="checkbox"/> _____

Family Medical History

Has anyone in your immediate family died of heart disease: YES NO _____

Has anyone in your family had an adverse reaction to anesthesia: YES NO _____

Has anyone in your family had an adverse reaction to Latex: YES NO _____

List any medical illnesses that run in your family: _____

Social History

Who do you live with now: SPOUSE BY YOURSELF OTHER FAMILY FRIENDS OTHER _____

Do you smoke tobacco? YES NO How many? _____ packs per day How long? _____ years

Do you drink alcohol? YES NO How many? _____ drinks per day How long? _____ years

DO YOU NOW HAVE ANY PROBLEMS RELATED TO THE FOLLOWING?

Constitutional Symptom	Eyes	Allergic Ear/Nose/Throat	Genitourinary
Fever Y N	Blurred Vision Y N	Hay Fever Y N	Ear Infection Y N
Chills Y N	Double Vision Y N	Drug Allergies Y N	Sore Throat Y N
Headache Y N	Pain Y N	Sinus Problem Y N	Urinary Frequency Y N
Other Y N	Other _____	Other _____	Other _____

Gastrointestinal	Neurological	Endocrine	Respiratory	Hematologic/Lymphatic
Abdominal Pain Y N	Tremors Y N	Excessive Thirst Y N	Frequent Cough Y N	Swollen Glands Y N
Nausea/Vomiting Y N	Dizzy Spells Y N	Too hot/cold Y N	Short of Breath Y N	Blood Clots Y N
Rectal Bleeding Y N	Numbness Y N	Tired/Sluggish Y N	Wheezing Y N	Bleeding Problem Y N

Cardiovascular	Integumentary	Musculoskeletal	Psychologic History	Other Medical Condition(s)
Chest Pain Y N	Skin Rash Y N	Joint Pain Y N	Depression Y N	_____
Varicose Y N	Boils Y N	Neck Pain Y N	Bipolar Disorder Y N	_____
High B.P. Y N	Persistent Itch Y N	Back Pain Y N	Schizophrenia Y N	_____
Other _____	Other _____	Other _____	Other _____	_____

Please use the back of this form if you need more room to write out your answers to any of the above questions