PATIENT HEALTH HISTORY

Patient Name: ___________________________________ **Date of Birth**: ________________________________

Referring Doctor: _________________________________ **Primary Care Dr:** _______________________________

Preferred Pharmacy: (name/location/phone #) ____

CURRENT MEDICATIONS: Please list all

Medication	Dose	Frequency
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		

ALLERGIES:

Do you have any drug allergies? ☐ Yes ☐ No

If yes, please describe the allergy and the reaction: ____

____

____

Do you have any other allergies we should know about? ☐ Yes ☐ No

If yes, please describe the allergy and the reaction: ____

FAMILY HISTORY:

Family Member	Alive/Deceased	Age	Medical Problem(s)
Mother	**A** **D**		
Father	**A** **D**		
Sister/Brother (please circle)	**A** **D**		
Sister/Brother (please circle)	**A** **D**		
Sister/Brother (please circle)	**A** **D**		
Sister/Brother (please circle)	**A** **D**		

Are there diseases which are common in your family? (If yes, please list.)____

____

Has any family member had a history of surgery for their back or neck, or had problems with their back or neck? ______

____

____

PATIENT HEALTH HISTORY

Patient Name: ______________________________

SOCIAL HISTORY:

Occupation: ______________________________

A: Physically, do you consider your job: ☐ Heavy ☐ Moderate ☐ Light

B: If retired, what was your prior occupation? ______________________________

Is someone available to care for you in your home if the need arises? ☐ Yes ☐ No

Do you live in a: ☐ House ☐ Apartment ☐ Other: ____________ #of stories: 1 2 3

Do you exercise regularly? ☐ Yes ☐ No Describe: ______________________________

Do you have a history of drug abuse or drug addition? ☐ Yes ☐ No

Alcohol use:

I use alcohol: ☐ Never ☐ Occasional ☐ Moderate ☐ Heavy

I have a history of heavy alcohol use: ☐ Yes ☐ No

Tobacco use:

Do you smoke? ☐ Yes ☐ No

I currently smoke ______packs per day and have smoked for _______years

Are you at risk for AIDS/HIV (e.g. sexual history, drug use, previous transfusion)? ☐ Yes ☐ No

PAST MEDICAL HISTORY: Please circle yes or no

Y N Use of Blood Thinners

Y N Anxiety Disorder

Y N Aortic Aneurism

Y N Arthritis

Y N Asthma

Y N Bipolar Disorder

Y N Cancer

Y N Congestive Heart Failure

Y N COPD (Chronic Obstructive Pulmonary Disease)

Y N Coronary Artery Disease

Y N (CVA) Stroke

Y N Degenerative Joint Disease

Y N Depression

Y N Diabetes

Y N Fibromyalgia

Y N Glaucoma

Y N Head Injury, with skull fracture

Y N Head Injury, without skull fracture

Y N HIV

Y N High Cholesterol

Y N High Blood Pressure

Y N Heart Attack

Y N Infectious Diseases (e.g. MRSA, TB)

Y N Osteoarthritis

Y N Osteoporosis

Y N Rheumatoid Arthritis

Y N Seizue Disorder

Y N Sleep Apnea

Y N Thyroid Disease

Y N Tuberculosis

Y N Vertebral Artery Stenosis

Complications from any surgery? ☐ No ☐ Yes - Please Explain______________________________

____

Do you take antibiotics before procedures or dental work? ☐ No ☐ Yes – Why? ______________________________

____

PATIENT HEALTH HISTORY

Patient Name: ______________________________________

PAST SURGICAL HISTORY: Please list all previous surgical procedures and the **date** your surgery was performed.

- ☐ Carpal Tunnel ______________________
- ☐ Craniotomy ______________________
- ☐ Discectomy ______________________
- ☐ Endarterectomy ______________________
- ☐ Intracathecal Pump ______________________
- ☐ Kyphoplasty ______________________
- ☐ Laminectomy-Cervical ______________________
- ☐ Laminectomy-Lumbar ______________________
- ☐ Spinal Cord Injury______________________
- ☐ Spinal Cord Stimulator ______________________
- ☐ Spinal Fusion – Lumbar ______________________
- ☐ Spinal Fusion – Thoracic ______________________
- ☐ Ulnar Nerve Release ______________________
- ☐ Vertebroplasty ______________________
- ☐ Other______________________

- ☐ Appendectomy ______________________
- ☐ C-Section ______________________
- ☐ Gall Bladder Removal ______________________
- ☐ Dental ______________________
- ☐ D&C ______________________
- ☐ Eye Surgery ______________________
- ☐ Fracture Repair ______________________
- ☐ Heart Surgery ______________________
  - ☐ Angioplasty ______________________
  - ☐ Bypass ______________________
  - ☐ Stent ______________________
  - ☐ Valve Replacement ___________________
  - ☐ Other ______________________

- ☐ Hernia Repair ______________________
- ☐ Hysterectomy ______________________
- ☐ Sinus Surgery ______________________
- ☐ Pancreatic Surgery ______________________
- ☐ Prostatectomy ______________________
- ☐ Large Bowel Resection ______________________
- ☐ Small Bowel Resection ______________________
- ☐ Stomach Resection ______________________
- ☐ Rotator Cuff Repair ______________________
- ☐ Thyroidectomy ______________________
  - ☐ Subtotal ______________________
  - ☐ Total ______________________
- ☐ Tonsillectomy ______________________
- ☐ Tubal Ligation ______________________
- ☐ Vasectomy ______________________
- ☐ Other ______________________

REASON FOR VISIT:

Describe your current problem and how it began. Please list all symptoms leading to today's visit: ____________________________

____

____

____

____

REASON FOR VISIT cont'd:

Date symptoms began: ____

Is your current problem a result of: ☐ Car Accident ☐ Work Accident ☐ Other/Unknown

Date of injury/accident: ____

Are you currently off work because of your problems? ☐ Yes ☐ No

Is a lawyer involved in your case? ☐ Yes ☐ No If yes, name of lawyer: ___________________________

PAIN HISTORY: (if not applicable, skip to next section)

What makes your symptoms better? ____

What makes your symptoms worse? ____

What specific activities are you having difficulty with that you hope to change as a result of treatment? ___________________________

____

____

In order to get better, you will be expected to participate in your treatment. This may include doing exercises or avoiding certain activities. How committed are you to participating in your treatment?

☐ Very Committed ☐ Somewhat Committed ☐ Not Very Committed

Is there anything that will limit your ability to participate in therapies? ☐ Yes ☐ No

Please Explain: ____

____

What tests have you had for your problem? ☐ X-rays ☐ Ct Scan ☐ MRI ☐ Blood Tests

☐ Other: ____

What treatments have you had for your problem? ☐ Medication(s) ☐ Physical Therapy ☐ Chiropractic
☐ Injections ☐ Surgery ☐ Other: ___________________________

Please describe their effect: ____

____

____

Would you consider surgery if it were recommended? ☐ Yes ☐ No

REVIEW OF SYSTEMS: Please circle yes or no

General:

Y	N	Weight gain greater than 10 lbs
Y	N	Weight loss greater than 10 lbs
Y	N	Obesity

Skin:

Y	N	Bruising

Neck:

Y	N	Neck Mass
Y	N	Swollen Glands

Respiratory:

Y	N	Chronic Cough
Y	N	Difficulty Breathing

PATIENT HEALTH HISTORY

Patient Name: ______________________________

HEENT:

Y N Blurred Vision
Y N Head Injury
Y N Double Vision
Y N Visual Disturbances
Y N Visual Loss
Y N Hearing Loss
Y N Ringing in the Ears
Y N Seasonal Allergies
Y N Hoarseness

Breast:

Y N Nipple Discharge

Cardiovascular:

Y N Chest Pain
Y N Irregular Heart Beat
Y N Elevated Blood Pressure
Y N Rapid Heart Beat
Y N Shortness of Breath
Y N Swelling of the Feet

Gastrointestinal:

Y N Change in Bowel Habits
Y N Indigestion
Y N Jaundice
Y N Nausea
Y N Vomiting

Genitourinary:

Y N Change in bladder habits
Y N Frequency
Y N Hesitancy
Y N Incontinence

Musculoskeletal:

Y N Back Pain
Y N Muscle Cramps
Y N Arm Weakness
Y N Leg Pain
Y N Neck Stiffness

Neurological:

Y N Decreased Memory
Y N Difficulty Speaking
Y N Dizziness
Y N Fainting
Y N Headaches
Y N Incoordination
Y N Loss of Consciousness
Y N Seizures
Y N Stroke
Y N Weakness in Extremeties
Y N Leg Pain with Walking

Psychiatric:

Y N Anxiety
Y N Depression
Y N Inability to Concentrate

Endocrine:

Y N Thyroid Problem

Hematology:

Y N Abnormal Bleeding
Y N Anemia
Y N Blood Clots

Other: ______________________________

____

The above information is accurate to the best of my knowledge:

______________________ ______________________ ____________

Please Print Name Signature Date

I HAVE REVIEWED THE ABOVE INFORMATION ***(Office Use Only)***

______________________ ______________________ ____________

Physician Name Signature Date Reviewed