ORTHOPEDIC SPECIALISTS, PC

SPINE PATIENT HISTORY

Name ____________________ Age ________ Height ________ Weight ________ Gender M / F

Occupation: ____________________ Primary Care Physician ____________________

Who referred you to Orthopedic Specialists, PC? Name ____________________

Where is your pain? Give percentage. Total should equal 100%

Back ______% Right Leg ______% Neck ______% Right Arm ______%
Left Leg ______% Left Arm ______%

How would you describe your pain? (circle all that apply)

Numbness Stabbing Ache Pins and Needles Burning Cramping

Using the symbols given below, mark the areas on your body where you feel the described sensations:

Front ***Back***

Numbness
II II II II

Pins and Needles
0 0 0 0 0

Burning
x x x x x

Stabbing
/////

Ache
^ ^ ^ ^

Circle **the number that best describes your current pain level.** (10 is the worst pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

Duration of pain: Occasional / Intermittent / Frequent / Constant

When did your current episode begin? ____________________ **Is this a work injury?** ____________________

Briefly describe: ____________________

____

____

What makes your Pain worse: Sitting Standing Walking Bending Lying down

What makes your pain better: Sitting Standing Walking Bending Lying down

Have you had any therapy for your back? Yes No For how long? ____________________

Have you had any shots in your back? Epidurals Facet Blocks None

Review of Systems: Check your current symptoms

❑ Rash
❑ Psoriasis
❑ Easy Bruising
❑ VisualDifficulty
❑ Hearing Loss
❑ Ringing in Ears
❑ Sinus Problems
❑ Breathing Problems
❑ Enlarged Thyroid
❑ Excessive Thirst/Appetite
❑ Sore Throat
❑ Hoarseness
❑ Snoring
❑ Irregular Heart Beat
❑ Heart Murmur
❑ Chest Pain
❑ Shortness of Breath
❑ Wheezing
❑ Headache/Migraine
❑ Convulsions/Seizures
❑ Cough/Sputum Production
❑ Weight Loss
❑ Nausea/Vomiting
❑ Blood in Stool
❑ Loss of Bowel Control
❑ Osteoporosis
❑ Joint Swelling
❑ Blood in Urine
❑ Painful Urination
❑ Loss of Bladder Control

Past Medical History: Please check the medical problems you have had

❑ Ulcers
❑ Cancer
❑ Kidney/Bladder Infection
❑ Diabetes
❑ Asthma
❑ Arthritis
❑ HIV
❑ Prostate Problems
❑ Heart Disease/Attack
❑ Depression/Psychiatric
❑ Tuberculosis
❑ Seizures
❑ Liver Disease/Hepatitis
❑ Stroke
❑ High Blood Pressure
❑ Blood Clots
❑ None
❑ Other

Previous Surgeries:

____

____

____

Family History: Check conditions in your immediate family

❑ Hypertension
❑ Diabetes
❑ Heart Disease
❑ Arthritis
❑ Cancer
❑ Stroke
❑ Bleeding Problems
❑ Anesthesia Difficulties

Medications:

MEDICINES	DOSE	HOW OFTEN

Allergies:

MEDICATION	REACTION	MEDICATION	REACTION

Social History:

Do you smoke? ______________ How much? _________ Date you quit smoking: _________________

Do you drink alcohol? _________ How much? _________

❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Significant other

How many children do you have? _________ Number living with you: _________

Work Status ❑ Working ❑ Paid leave ❑ Unpaid leave ❑ Unemployed

❑ Disabled ❑ Student ❑ Retired ❑ Other ________________________________

Patient Signature: ________________________ Doctor Signature: ______________________ Date:_______________

Patient Signature: ________________________ Doctor Signature: ______________________ Date:_______________
(Reviewed History Form)