

**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 _____

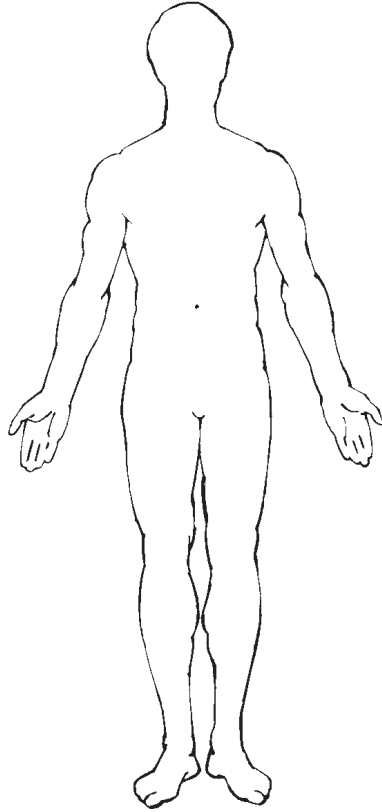
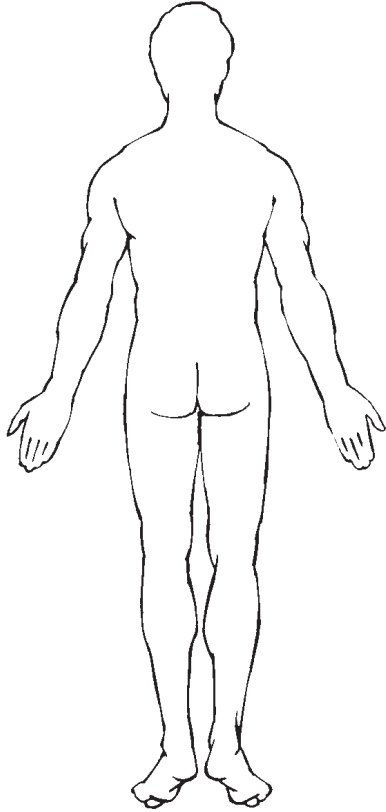
Where is your pain? Give percentage. Total should equal 100%

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:

<i>Front</i>		<i>Back</i>
	<p>Numbness </p> <p>Pins and Needles 0 0 0 0 0</p> <p>Burning x x x x x</p> <p>Stabbing ////</p> <p>Ache ^ ^ ^ ^</p>	

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
- Visual Difficulty
- 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)