PATIENT MEDICAL HISTORY FORM

PLEASE ANSWER ALL QUESTIONS AS ACCURATELY AS POSSIBLE

IF IT DOES NOT APPLY TO YOU, PLEASE WRITE N/A

Today's Date:_____

Name:_____

Height:_____ Weight:_____

Gender: Male / Female

Current Employer:_____Occupation:_____

How long have you been employed in this position?_____

Primary Care Physician (PCP):_____

Phone:_____ Fax:_____

Address:_____

Who referred you to this office?_____

Pharmacy:_____ Phone:_____

Is this injury work related? Yes / No

Is this injury related to a motor vehicle accident? Yes / No

If you answered yes to any of the above, what was the date of your injury?_____

Have you had any difficulties controlling your bowel or bladder?_____

Have you had any difficulties with sexual function? Yes / No

Have you ever been treated or evaluated for your neck and/or back before? No / Neck / Back

If yes, what kind of treatment have you undergone?

Physical therapy Injections Chiropractic care Acupuncture Other:_____

Have you undergone imaging of your neck and/or back? Yes / No

If yes, what types of imaging studies have you had?

MRI CT CT-Myelogram X-Rays

What is your primary complaint today: Neck pain / Arm pain / Low back pain / Leg pain

What makes your pain worse?_____

What makes your pain better?_____

Is your pain worse at a time of day?_____

Do you have any numbness, tingling, and/or weakness of your arms or legs? If yes, please describe:

_____

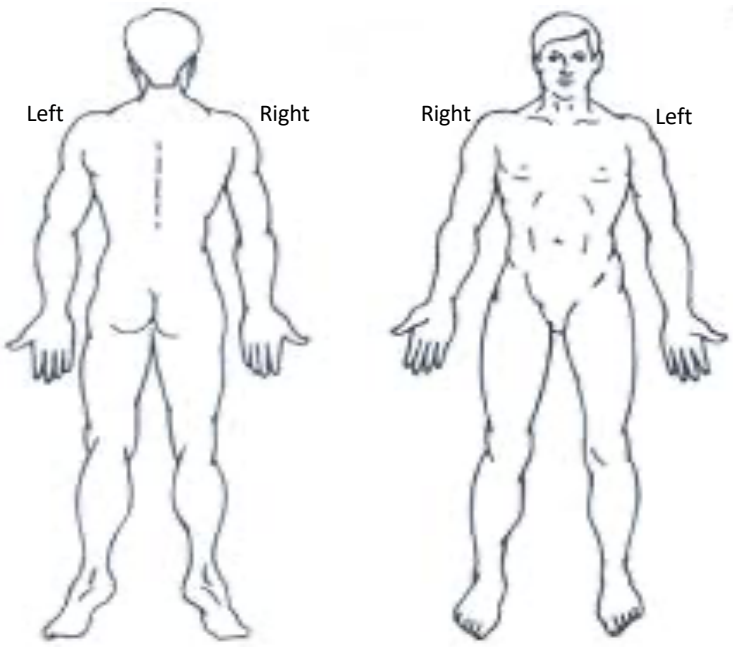
_____

Please indicate the location of your pain using the scale below:

Pain ///////

Numbness ∴

Burning +++



Please list any past surgeries you have had on your neck and/or back:

Surgery:_____ Date of Procedure:_____

Surgery:_____ Date of Procedure:_____

Surgery:_____ Date of Procedure:_____

Surgery:_____ Date of Procedure:_____

Please list all medications that you are currently taking (prescription and non-prescription):

_____

_____

_____

_____

Are you allergic to any medications? Yes / No

If yes, please list the medication and your reaction(s) below:

Medication:_____ Reaction(s):_____

Medication:_____ Reaction(s):_____

Medication:_____ Reaction(s):_____

Are you allergic to latex? Yes / No Are you allergic to nickel? Yes / No

Do you currently use tobacco products? Yes / No

If yes, how much per day?_____ How many years?_____

Have you had a prior history of tobacco use? Yes / No

If yes, when did you quit?_____

Are you currently using any of the following recreational drugs?

Marijuana Cocaine Methamphetamines Heroin Other:_____

Do you have any history of recreational drug use? Yes / No

Have you ever taken prescription narcotics for more than 3 months? Yes / No

Do you drink alcohol? Yes / No

If yes, how much and how often?_____

Do you have any implantable medical devices or retained metal in your body? (i.e. pacemaker, defibrillator, joint replacements, stents, etc.) Yes / No

If yes, please describe:_____

Please list all prior surgeries and the estimated date of the procedure:

_____

_____

_____

Have you ever been hospitalized? If yes, when and for what reason?

_____

_____

_____

MEDICAL HISTORY

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS?

CANCER	YES	NO
DIABETES	YES	NO
HYPERTENSION (HIGH BLOOD PRESSURE)	YES	NO
HYPERLIPIDEMIA (HIGH CHOLESTEROL)	YES	NO
MYOCARDIAL INFARCTION (HEART ATTACK)	YES	NO
STROKE	YES	NO
LUNG DISEASE	YES	NO
SLEEP APNEA	YES	NO
SUBSTANCE ADDICTION	YES	NO
DEPRESSION	YES	NO
ANXIETY	YES	NO
MRSA/C-DIFF (PLEASE CIRCLE)	YES	NO
HEPATITIS A/B/C (PLEASE CIRCLE)	YES	NO
HIV/AIDS (PLEASE CIRCLE)	YES	NO

OTHER: _____

DO YOU HAVE A FAMILY HISTORY OF THE FOLLOWING MEDICAL PROBLEMS?

			Relationship
CANCER	YES	NO	_____
DIABETES	YES	NO	_____
HYPERTENSION	YES	NO	_____
HEART ATTACK	YES	NO	_____
STROKE	YES	NO	_____
LUNG DISEASE	YES	NO	_____
SLEEP APNEA	YES	NO	_____

OTHER:_____

PATIENT SIGNATURE:

X_____ Date:_____

OFFICE USE ONLY:

PHYSICIAN/PA/NP REVIEWER_____DATE:_____