

PATIENT HISTORY

Name _____ Phone _____ Birth Date _____ Age _____ Sex _____

Who requested that you see our physicians? _____ Phone _____

Family Physician or Internist: _____ Phone _____

What is your major problem or complaint? _____

When did your problem start? _____ Was there a specific injury? _____ Date of Injury _____

DO YOU CONSIDER THIS A WORK OR AUTO RELATED INJURY? _____ Why? _____

Have you seen other doctors for this problem? _____ Who? _____

PAST MEDICAL HISTORY (check all present):

- Diabetes
- Hypertension
- Hepatitis/liver disease
- Thyroid disease
- High Cholesterol
- Other: _____
- Heart Trouble
- Cancer
- AIDS or HIV
- Kidney disease
- Stroke
- Serious Infection
- Psychiatric illness
- COPD/asthma
- Arthritis/gout
- Blood clots
- Ulcer/stomach problem
- Head injury
- Convulsions
- Hereditary defects
- Trauma
- Anemia

Previous surgeries (include year) 1) _____ 2) _____

Do you have metal in your body? _____ **If, yes, is it MRI compatible (titanium)?** _____

Have you ever had problems with anesthesia with previous surgeries _____ Yes _____ No

Systems review (check all present):

- Rash/unusual mole
- Night sweats
- Fever
- Fatigue
- Weight change
- Other: _____
- Easy bruising
- Sinus problems
- Bleeding tendency
- Bowel problems
- Bladder difficulties
- Chest pain
- Cold extremities
- Shortness of breath
- Joint pain
- Back pain
- Headaches
- Dizziness
- Tremors
- Difficulty walking
- Sleeping problems
- Paralysis
- Memory loss
- Hearing loss
- Visual change
- Numbness/tingling

Explain: _____

Medications you are taking (include dose, over the counter drugs and vitamins): _____

Preferred Pharmacy: _____ **Phone:** _____

Drug Allergies and Reactions: _____

Allergy to: _____ Latex _____ Betadine _____ Shellfish _____ IV Contrast/Dye

Diseases that run in the family (include deceased family members): _____

Do you smoke now? _____ Packs per day? _____ How long? _____ Have you in the past? _____ When did you quit? _____

Do you drink alcohol excessively? _____ Do you use drugs? _____ Have you been treated for substance abuse? _____

Marital Status _____ Number of children _____ Do you have a healthcare directive or power of attorney? _____

Occupation _____ Height _____ Weight _____