MR#

Medical History Form

First Name, Middle Initial Last Name

Today's Date: ___________

Date of Birth: Gender: Height ________ Weight ________ pounds

Problem is due to ☐ Arthritis ☐ Car Accident ☐ Fall ☐ Sports Injury ☐ Work Related ☐ Other ________________________

If an injury, is there litigation pending? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Have you or any family member (parent, grandparent, sibling, children) had any of the following medical problems?

☐ **Denies All**

You	Family	Denies	
☐	☐	☐	Anemia (explain) ____________________
☐	☐	☐	Arthritis (explain) ____________________
☐	☐	☐	Arthritis—Rheumatoid (explain) ____________________
☐	☐	☐	Arthritis--Osteoarthritis (explain) ____________________
☐	☐	☐	Arthritis--Osteopenia (explain) ____________________
☐	☐	☐	Arthritis—Osteoporosis (explain) ____________________
☐	☐	☐	Asthma (explain) ____________________
☐	☐	☐	Atrial Fibrillation/or Irregular Heartbeat (explain) ____________________
☐	☐	☐	Balance Problems (explain) ____________________
☐	☐	☐	Bleeding Disorder (explain) ____________________
☐	☐	☐	Blood Clots/Pulmonary Embolism (explain) ____________________
☐	☐	☐	Cancer (explain) ____________________
☐	☐	☐	Colitis (explain) ____________________
☐	☐	☐	Depression (explain) ____________________
☐	☐	☐	Diabetes (explain) ____________________
☐	☐	☐	Emphysema (explain) ____________________
☐	☐	☐	Endocrine Disorders (explain) ____________________
☐	☐	☐	Heart Trouble/Disease (explain) ____________________
☐	☐	☐	Hepatitis (explain) ____________________
☐	☐	☐	High Blood Pressure (explain) ____________________
☐	☐	☐	HIV/AIDS (explain) ____________________
☐	☐	☐	Kidney Stones (explain) ____________________
☐	☐	☐	Lyme Disease (explain) ____________________
☐	☐	☐	Nervous Disorder (explain) ____________________

☐ ☐ ☐ Phlebitis (explain) ______________________________

☐ ☐ ☐ Reflux (explain) ______________________________

You Family Denies

☐ ☐ ☐ Sleep Apnea (explain) ______________________________

☐ ☐ ☐ Stroke (explain) ______________________________

☐ ☐ ☐ Tuberculosis (explain) ______________________________

☐ ☐ ☐ Ulcers (explain) ______________________________

☐ ☐ ☐ Others (explain) ______________________________

☐ ☐ None of the above

PAST SURGICAL HISTORY (include ALL surgeries) Or you may select ☐ None (I have not had any past surgical procedures)

Type of Surgery ____________ Year ______ Type of Surgery ____________ Year ______

Type of Surgery ____________ Year ______ Type of Surgery ____________ Year ______

Type of Surgery ____________ Year ______ Type of Surgery ____________ Year ______

Type of Surgery ____________ Year ______ Type of Surgery ____________ Year ______

ASSOCIATED HEALTH

Are you pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No

Have you (or are you) receiving all the standard child immunizations? ☐ Yes ☐ No--please explain ____________

Have you ever received a tetanus shot? ☐ No ☐ Yes--please provide approximate date of last tetanus shot ____________

Have you had a prior blood transfusion? ☐ No ☐ Yes--when? ____________

Have you ever had problems with anesthesia? ☐ No ☐ Yes--when? ____________

If you are over the age of 50 years old please answer the following:

Have you had two or more falls in the past 12 months? ☐ Yes (1100F) ☐ No (1101F)

Have you fallen and injured yourself in the last 12 months? ☐ Yes (1100F) ☐ No (1101F)

Have you had a DEXA (bone density) scan in the last 12 months? ☐ Yes (3095F/ G8399) ☐ No (3096F-2P/ G8400)

Have you been treated with medication for osteoporosis in the past 12 months? ☐ Yes (4005F) ☐ No (4005F-2P)

PRESCRIPTION/ NON-PRESCRIPTION MEDICATIONS (including herbal supplements and vitamins)

If you are currently not taking any medications (including herbal supplements/vitamins) select ☐ None

Name	Dosage	Amount Taken Per Day

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ALLERGIES:

☐ **I do not have any known Allergies to the following selections below.**

☐ Aspirin Type of reaction: ______________________________

☐ Codeine/Pain Medications Type of reaction: ______________________________

☐ Contrast Type of reaction: ______________________________

☐ Iodine Type of reaction: ______________________________

☐ Food Type of reaction: ______________________________

☐ Latex Type of reaction: ______________________________

☐ Lidocaine Type of reaction: ______________________________

☐ Local Anesthetics Type of reaction: ______________________________

☐ Novocain Type of reaction: ______________________________

☐ Metal/Jewelry Type of reaction: ______________________________

☐ Penicillin/Antibiotics Type of reaction: ______________________________

☐ Shellfish Type of reaction: ______________________________

☐ Sulfa Type of reaction: ______________________________

☐ Others____________ Type of reaction: ______________________________

RISK FACTORS

Tobacco Product Use

Do you use tobacco? ☐ No (1000F/1036F/G8457/G8403) ☐ Yes (1000F/ 1034F/ G8457/ G8403)--number of packs per day_____

Do you smoke cigarettes? ☐ No ☐ Yes--how often _______________

Did you ever smoke cigarettes? ☐ No ☐ Yes What year did you quit___________

Do you smoke cigars? ☐ No ☐ Yes--how often _______________

Did you ever smoke Cigars ☐ No ☐ Yes What year did you quit___________

Do you use smokeless Tobacco products? ☐ No (100F/ 1035F/ G8457) ☐ Yes--how often _____________

Did you ever use smokeless Tobacco products? ☐ No ☐ Yes What year did you quit___________

History of drug use ☐ Yes ☐ No

Alcohol use ☐ Never ☐ Occasional ☐ Daily ☐ Heavy History of alcoholism? ☐ Yes ☐ No

Type(s) of exercise/sports activity: ______________________________ How often? ________# times per week

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SOCIAL HISTORY

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other ____________________

Do you have Children? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No--who do you live with? ____________________

Are you working now? ☐ No-- ☐ Disabled ☐ Retired--Occupation ____________________

☐ Yes--Occupation ____________________
Is your work ☐ Physical ☐ Sedentary ☐ Light Duty ☐ Regular Duty

REVIEW OF SYSTEMS (are you currently having problems with any of the following:

Denies All ☐ Denies All (Select this option if you wish to deny all of the selections below)

General ☐ Denies
☐ Chills ☐ Fatigue ☐ Fever ☐ Weight change

Skin ☐ Denies
☐ Breast lump ☐ Hair change ☐ Nail change ☐ Rash/itching/psoriasis

HEENT ☐ Denies
☐ Blurred vision ☐ Eye disease ☐ Glaucoma ☐ Hearing loss/ringing ☐ Nose bleeds
☐ Sinus problems ☐ Sore throat

Respiratory ☐ Denies
☐ Bronchitis ☐ Cough ☐ Short of breath ☐ Wheezing

Cardiovascular ☐ Denies
☐ Chest pain ☐ Heart trouble ☐ Palpitations ☐ Swelling

Gastrointestinal ☐ Denies
☐ Bowel problem/colitis ☐ Nausea/vomit ☐ Rectal bleeding ☐ Stomach pain

Genitourinary ☐ Denies
☐ Blood in urine ☐ Foul odor/cloudiness ☐ Frequency ☐ Kidney stones ☐ Menstrual problems ☐ Retention
☐ Sexual problems ☐ Testicle pain

Musculoskeletal ☐ Denies
☐ Joint pain ☐ Joint swelling ☐ Pain/cramps ☐ Trouble walking

Neurological ☐ Denies
☐ Headaches ☐ Numbness ☐ Seizures ☐ Tremors ☐ Weakness

Psychiatric ☐ Denies
☐ Confusion ☐ Depression ☐ insomnia

Endocrine ☐ Denies
☐ Excessive urination ☐ Hormone problem ☐ Thyroid disease

Hematologic ☐ Denies
☐ Bruise easily ☐ Enlarged glands ☐ Slow to heal

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VISUAL ANALOGUE SCALE PAIN ASSESSMENT Please circle the number that best answers the question.

What is your pain RIGHT NOW?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

What is your TYPICAL or AVERAGE pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

OSWESTRY DISABILITY INDEX Please circle the number of the answer that best describes your condition.

Pain Intensity

5—Pain medication has no effect on the pain and I do not use.
4—Pain medication gives very little relief from pain.
3—Pain medication gives moderate relief from pain.
2—Pain medication gives complete relief from pain.
1—Pain is bad but I manage without taking pain medication.
0—I can tolerate the pain I have without taking medication.

Personal Care

5—I do not get dressed; wash with difficulty and stay in bed.
4—I need help every day in most aspects of self care.
3—I need some help but manage most of my personal care.
2—It is painful to look after myself; I am slow and careful.
1—I can look after myself normally but it causes extra pain.
0—I can look after myself normally without causing extra pain.

Lifting

5—I cannot lift or carry anything at all.
4—I can lift only very light weights.
3—Pain prevents me from lifting heavy weights, but I can manage medium weights if they are conveniently positioned.
2—Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned.
1—I can lift heavy weights but it causes extra pain.
0—I can lift heavy weights without extra pain.

Walking

5—I am in bed most of the time and have to crawl to the toilet.
4—I can only walk using a stick or crutches.
3—Pain prevents me walking more than 0.25 miles.
2—Pain prevents me walking more than 0.5 miles.
1—Pain prevents me walking more than 1 mile.
0—Pain does not prevent me walking any distance.

Sitting

5—Pain prevents me from sitting at all.
4—Pain prevents me from sitting more than 10 minutes.
3—Pain prevents me from sitting more than 0.5 hours.
2—Pain prevents me sitting more than 1 hour
1—I can only sit in my favorite chair as long as I like.
0—I can sit in any chair as long as I like.

Standing (Remember standing is not walking)

5—Pain prevents me from standing at all.
4—Pain prevents me from standing for more than 10 minutes.
3—Pain prevents me from standing for more than 30 minutes.
2—Pain prevents me from standing for more than 1 hour.
1—I can stand as long as I want but it gives me extra pain.
0—I can stand as long as I want without extra pain.

Sleeping

5—Pain prevents me from sleeping at all.
4—Even when I take medicine I have less than 2 hours of sleep.
3—Even when I take medicine I have less than 4 hours of sleep.
2—Even when I take medicine I have less than 6 hours of sleep.
1—I can sleep well only by using medicine.
0—Pain does not prevent me from sleeping well.

Sex Life (by pain of fear of causing pain)

5—Pain prevents any sex life at all.
4—My sex life is nearly absent because of pain.
3—My sex life is severely restricted by pain.
2—My sex life is nearly normal but very painful.
1—My sex life is normal but causes extra pain.
0—My sex life is normal and causes no extra pain.

Social Life

5—I have no social life because of pain.
4—Pain has restricted my social life to my home.
3—Pain has restricted my social life and I do not go out as often.
2—Pain has no significant effect on my social life apart from limiting energetic interest such as dancing.
1—My social life is normal but increase the degree of pain.
0—My social life is normal and give me no extra pain.

Traveling

5—Pain prevents me from traveling except to the doctor or home.
4—Pain restricts me to short necessary journeys under 30 minutes.
3—Pain restricts me to journeys of less than 1 hour.
2—Pain is bad but I manage journeys over 2 hours.
1—I can travel anywhere but it gives me extra pain.
0—I can travel anywhere without extra pain.

Patient/Guardian Statement: to the best of my knowledge, the above information is accurate and complete.

Name of person completing the form___________________________ Relationship to patient__________________________

Signature of person completing the form____ Date _______________

Provider Statement: I have reviewed the questionnaire with the patient.

Medical Professional signature ____ Date ______________

Medical Professional signature ____ Date ______________

Spine Consultants, LLC
www.spineconsultants.org

Patient Demographics

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First Name, Middle Initial Last Name Gender Date of Birth:

Address City State Zip Code

Home Phone Cell Phone Work Phone Email address
(will be used to communicate about the services we provide to you) ______________________

Social Security Number: Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other ________

Race ☐ Asian ☐ American Indian/Alaska Native ☐ Black/African American ☐ Native Hawaiian ☐ More than one race ☐ Other Pacific Islander ☐ Refused to Report/Unreported ☐ White

Ethnicity ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Refused to Report/Unreported

Primary Language ☐ English ☐ Spanish ☐ Hearing Impaired ☐ Other ______________

Pharmacy Name ______________________ City ____________ Phone ________

Primary Care Physician Name ______________________ City ____________ Phone ________

Referring Physician Name ______________________ City ____________ Phone ________

Patient Employment Information

Occupation ______________________ ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Disability ☐ Self Employed ☐ Student

Employer Name ______________________ Employer Address ______________________ Employer Phone ____________

Guarantor (Responsible Party) Information

Guarantor First Name: Guarantor Last Name:

☐ Same as patient

Guarantor Date of Birth: Guarantor Social Security Number:

Guarantor Address City State Zip Code

Guarantor Phone ______________________ ☐ Home ☐ Cell ☐ Work

Relationship to patient: ☐ Parent ☐ Handicapped dependent ☐ Spouse ☐ Other ____________

Health Insurance Information

Primary Insurance Company name:

Policy #: ____________ Group #: ____________

Co-pay amount: ______________________

Subscriber's Name:

☐ Same as patient

Secondary Insurance Company name:

Policy #: ____________ Group #: ____________

Co-pay amount: ______________________

Subscriber's Name:

☐ Same as patient

How did you hear about us? Who can we thank for referring you?

☐ Patient (name)____________ ☐ Physician (name)

☐ Practice Website ☐ Insurance carrier ____________

☐ Internet (Site)____________ ☐ Other____________

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Is your injury due to (check appropriate boxes) ☐ No ☐ Yes—**Please complete appropriate information below.**

☐ Work Accident Date of Accident: ________________ Body Part Injured _____________________________

WC Insurance Carrier name «PL1WCarrName» Adjuster name ___________________________

Adjuster phone number ____________ Claim # __________________ Last date worked ______________

☐ Motor Vehicle Accident Date of Accident: ________________ Body Part Injured _____________________________

Accident Location City & State _________________

Motor Vehicle Insurance Carrier Name «PL1MCarrName» Adjuster Name____________________

Adjuster phone number _____________________ Policy # __________________________________

☐ Personal Injury Date of Accident: ________________ Body Part Injured _____________________________

Insurance Carrier name ___________________________ Adjuster name ___________________________

Adjuster phone number _____________________ Claim # ___________________________________

☐ Attorney retained to represent you Attorney Firm Name _________________________ Attorney Name ______________________

Attorney Address____ Phone number: ________________

By signing this document I certify the above information is complete and accurate.

Name of person completing the form_________________________________

Relationship to patient____

Signature of person completing the form______________________________ Date ________________

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Phone Message and Contact Authorization

Patient Name: ____ Date of Birth:

I give permission for the medical practice to leave messages containing medical and/or financial information on an answering machine:

Cell Phone__________________ ☐ Yes ☐ No—the appointment date, time & location will be left

Home Phone________________ ☐ Yes ☐ No--the appointment date, time & location will be left

Work Phone_________________ ☐ Yes ☐ No--the appointment date, time & location will be left

Emergency Contact Information: I give authorization to the doctors, medical providers and medical practice staff to contact in the event of an emergency:

Name	Relationship	Phone	
			☐ Home ☐ Cell ☐ Work
			☐ Home ☐ Cell ☐ Work
			☐ Home ☐ Cell ☐ Work
			☐ Home ☐ Cell ☐ Work

Contact Information: I give authorization to the doctors, medical providers and medical practice staff to discuss my medical and/or financial information with the following people:

Name	Relationship	Phone	
			☐ Home ☐ Cell ☐ Work
			☐ Home ☐ Cell ☐ Work
			☐ Home ☐ Cell ☐ Work
			☐ Home ☐ Cell ☐ Work

This consent expires one year after the date of signature. I understand it is the patient's responsibility to inform the medical practice of any desired changes. By signing this document I certify the above information is complete and accurate.

Name of person completing the form___________________________

Relationship to patient____

Signature of person completing the form_________________________ Date _______________