

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_/\_\_\_/\_\_\_

Appointment with:

Appointment Date: \_\_\_/\_\_\_/\_\_\_

Dr. Heilman    Dr. Kozak    Dr. Williamson

**PAST MEDICAL HISTORY**

Do you have, or have you had, any of the following?

	Yes	No	Date Diagnosed	Hospitalization/Surgery
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Polio	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Do you have any allergies to the following? If yes, please specify to what you are allergic, type of reaction, and how reaction was treated.

	Yes	No	Allergy/Reaction/Treatment
Food	<input type="checkbox"/>	<input type="checkbox"/>	_____
Environment (i.e. hay fever)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you have any of these iodine allergies? If yes, please specify type of reaction and how reaction was treated.

	Yes	No	Reaction/Treatment
Betadine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Iodine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shell fish	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you have any allergies to medications? If yes, please specify type of reaction and how reaction was treated.

	Yes	No	
	<input type="checkbox"/>	<input type="checkbox"/>	
Medication			Reaction/Treatment
_____			_____
_____			_____
_____			_____

Have you ever had an allergic reaction to anesthesia? If yes, please specify.

	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>
_____		
_____		

**PAST MEDICAL HISTORY**

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Have you had any previous non-spinal injuries (i.e. fractures, sports injuries, injuries in motor vehicle accidents)? If yes, please specify date of injury, area of body, how the injury occurred, what treatment you received, and any continuing problems.

Yes No

Date Area of Body How Treatment Continuing Problems

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Have you had any previous spinal injuries? If yes, please specify date of injury, area of spine, how the injury occurred, what treatment you received, and how long symptoms lasted.

Yes No

Date Area of Body How Treatment Symptom Duration

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Have you had any previous non-spinal surgeries? If yes, please specify the date, type of surgery, physician, hospital/facility, and city/state.

Yes No

Date Surgery Physician Hospital/Facility City/State

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Have you had any previous spinal surgeries? If yes, please specify the date, area of spine and type of surgery, physician, hospital/facility, and city/state.

Yes No

Date Area of Spine/Surgery Physician Hospital/Facility City/State

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Are you currently taking medication? If yes, please specify.

Yes No

Medication Dosage Frequency

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**PAST MEDICAL HISTORY**

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**PSYCHOSOCIAL/PERSONAL HISTORY**

Marital Status       Single       Married       Divorced       Widowed

Number of Children \_\_\_\_\_

Please explain home environment/surroundings which could increase spinal symptoms.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is your occupation/profession/trade?

\_\_\_\_\_

Housewife       Retired

Does your job include any of the following? If yes, please specify the hours per day or the weight involved.

	Yes	No	Hours	Weight
Handwriting	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
On hands and knees	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Operating heavy equipment	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Repeated activities	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Standing	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Typing	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Walking	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Working overhead with hands	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Other			_____	_____

Please specify:

\_\_\_\_\_

Do you or have you smoked or used another form of tobacco?

Yes    No    Quit

If yes, length of time \_\_\_\_\_, form of tobacco \_\_\_\_\_, number of packs/times per day \_\_\_\_\_. When did you quit? \_\_\_\_\_

Do you or have you used alcohol or other chemical substances?

Yes    No    Quit

If yes, type of alcohol/chemical substance \_\_\_\_\_, number of drinks/times per week \_\_\_\_\_. When did you quit? \_\_\_\_\_

**PAST MEDICAL HISTORY**

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**FAMILY HISTORY**

Is there a history of cancer, diabetes, or heart problems in your family? If yes, please specify relative, type of cancer or other disease, and at what age the disease was first detected.

Yes    No  
   

Relative	Type	Age
_____		
_____		
_____		

Is there a history of arthritis or spinal problems in your family? If yes, please specify relative, type of problem, and at what age the problem first arose.

Yes    No  
   

Relative	Type	Age
_____		
_____		
_____		

Is there a history of allergic anesthetic reactions in your family? If yes, please specify relative and type of allergic reaction.

Yes    No  
   

Relative	Reaction
_____	
_____	
_____	

## PAST MEDICAL HISTORY

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### REVIEW OF SYSTEMS

Do you have, or have had, any of the following?

	Yes	No
Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Back pain at night	<input type="checkbox"/>	<input type="checkbox"/>
Backache	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>
Changes in bladder habits	<input type="checkbox"/>	<input type="checkbox"/>
Changes in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>
Crying spells	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Drug abuse	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Heel pain	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain/stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>
Neckache	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Past blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Problems with wound healing	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>
Testicular pain	<input type="checkbox"/>	<input type="checkbox"/>
Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Visual problems	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>