**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:

***Front*** ***Back***

**Numbness**
**II II II II**

**Pins and Needles**
**0 0 0 0 0**

**Burning**
**x x x x x**

**Stabbing**
***/////***

**Ache**
**^ ^ ^ ^**

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
- ❑ VisualDifficulty
- ❑ 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)