

**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 \_\_\_\_\_

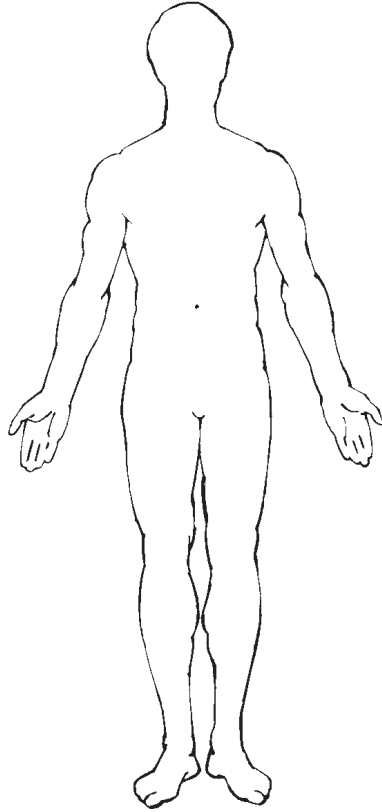
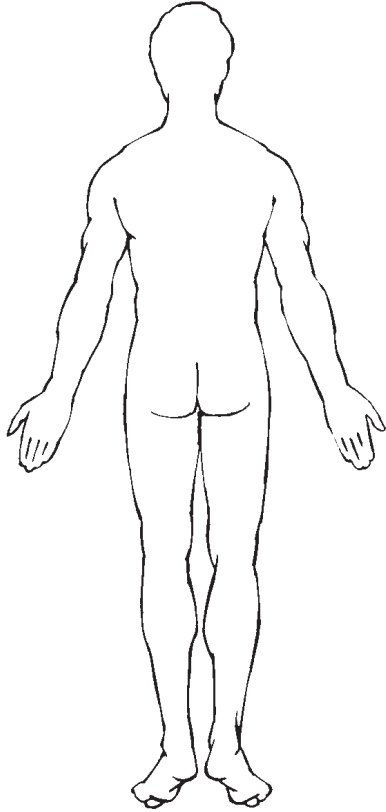
Where is your pain? Give percentage. Total should equal 100%

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:

<i>Front</i>		<i>Back</i>
	<p><b>Numbness</b>            </p> <p><b>Pins and Needles</b> 0 0 0 0 0</p> <p><b>Burning</b> x x x x x</p> <p><b>Stabbing</b> ////</p> <p><b>Ache</b> ^ ^ ^ ^</p>	

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
- Visual Difficulty
- 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:**

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**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)