

PATIENT MEDICAL HISTORY FORM

TODAY'S DATE _____

NAME _____ AGE _____

RIGHT or LEFT HANDED ? R L HEIGHT _____ WEIGHT _____

OCCUPATION _____ EMPLOYER _____

1. NAMES OF NEUROSURGEONS YOU HAVE SEEN. _____
WHO REFERRED YOU TO OUR OFFICE? _____
WHO IS YOUR PRIMARY CARE PHYSICIAN? _____
PHYSICIAN'S ADDRESS: _____
DO YOU HAVE AN ATTORNEY HELPING YOU? _____ ATTORNEY'S NAME _____
ATTORNEY'S ADDRESS, IF KNOWN _____

2. (A) APPROXIMATELY WHAT DATE DID YOUR PAIN START? _____
(B) IN YOUR OWN WORDS, PLEASE TELL US WHAT HAPPENED AND WHY YOU ARE HERE TODAY TO SEE THE DOCTOR.

3. IS THIS A WORK INJURY OR AUTO ACCIDENT ? WHAT IS YOUR WORK STATUS?
 Working full duty. -- Any absences? _____
 Working modified duty. -- Specify: _____
 Off work. -- Since when? _____

4. PLEASE LIST ALL THE DOCTORS YOU HAVE SEEN FOR THIS PROBLEM _____

5. WHAT TREATMENTS FOR THIS PROBLEM HAVE YOU HAD? (Check all that apply.)

	MADE PAIN BETTER	MADE PAIN WORSE
<input type="checkbox"/> Medication Therapy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chiropractic	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Epidural Steroid Injection	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physiatrist / Osteopath	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Back School	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pain Treatment Center	<input type="checkbox"/>	<input type="checkbox"/>

6. HAVE YOUR SLEEPING PATTERNS BEEN AFFECTED BY THE PAIN?
 no yes --- Please describe: _____

7. WHAT TESTS HAVE YOU HAD DONE? (Check all that apply.)

- MRI
- CT Scan
- EMG
- Myelogram

8. HAVE YOU EVER HAD NECK OR BACK SURGERY? _____
DATE _____ PROCEDURE _____ SURGEON _____

9. LIST ANY ALLERGIES: _____

10. WHAT OTHER MAJOR ILLNESSES HAVE YOU HAD? (Check all that apply.)

- Stomach Problems (Ulcers)
- Diabetes
- High Blood Pressure
- Heart Disease
- Arthritis
- Cancer -- Type: _____
- Gout
- Seizure Disorder
- Prolonged cough longer than 3 weeks, bloody sputum, night sweats, fever, weight loss.
- Other: _____

11. WHAT OTHER SURGICAL OPERATIONS HAVE YOU HAD?

PROCEDURE _____	DATE _____
PROCEDURE _____	DATE _____
PROCEDURE _____	DATE _____
PROCEDURE _____	DATE _____
PROCEDURE _____	DATE _____

12. ARE THERE ANY DISEASES WHICH RUN IN YOUR FAMILY? _____

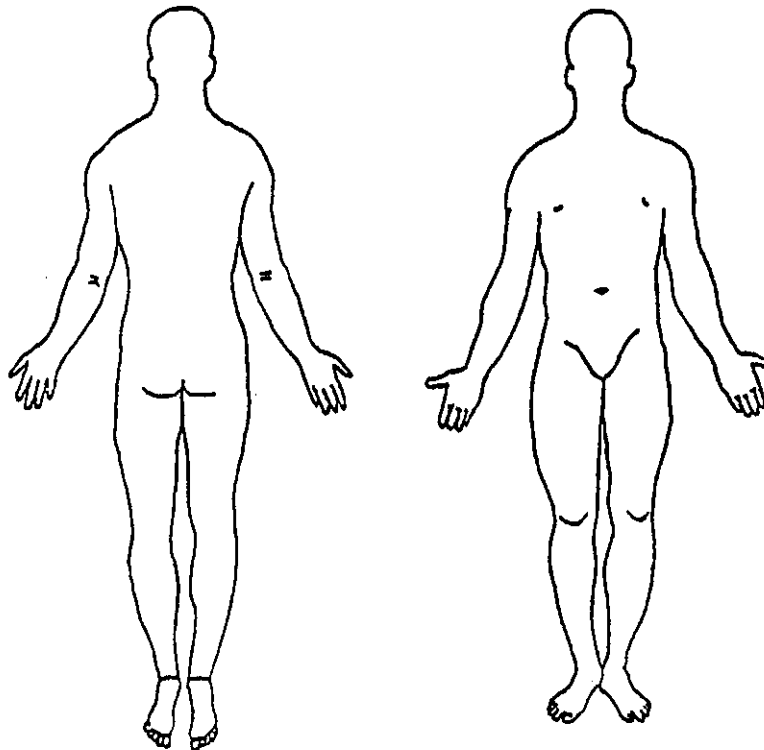
13. PLEASE LIST ALL CURRENT MEDICATIONS BEING TAKEN:

NAME	DOSAGE	FREQUENCY TAKEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

14. ARE YOU SINGLE WIDOWED MARRIED DIVORCED
 DO YOU SMOKE CIGARETTES? _____ HOW MANY PACKS PER DAY? _____
 DO YOU DRINK ALCOHOLIC BEVERAGES? _____ HOW MUCH? HOW OFTEN? _____

15. MARK THE AREAS OF YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS. USE THE APPROPRIATE SYMBOL, MARKING ALL AREAS AFFECTED, INCLUDING RADIATING SYMPTOMS.

NUMBNESS	PAIN
---	x x x
---	x x x
---	x x x



16. PAIN IS : (Check all that apply.)

- 1 Burning
- 2 Sharp
- 3 Shooting

17. PAIN IS WORSE IN: (Check all that apply.)

- | | |
|---------------------------------|--------------------------------|
| 1 <input type="checkbox"/> Back | 3 <input type="checkbox"/> Leg |
| 2 <input type="checkbox"/> Neck | 4 <input type="checkbox"/> Arm |