PATIENT RECHECK FORM

MEDICAL HISTORY

List **CURRENT** spine complaints:

List **CURRENT** non-spinal medical problems (ie: high blood pressure, diabetes, cancer, reflux, ect...):

Are you currently pregnant? ☐ YES ☐ NO Are you currently breastfeeding? ☐ YES ☐ NO

List **ALL CURRENT** medications:

Do you need any refills? ☐ YES ☐ NO

List **ALL** medication allergies: ☐ No known drug allergies

Social History:

Who do you live with? ☐ Family ☐ Friends ☐ Alone

Do you use nicotine products? ☐ No ☐ Yes Type & Amount (cigarettes/vape/chew/ect): _____

Do you drink alcohol? ☐ No ☐ Rarely ☐ Socially ☐ Daily

Did you bring any new imaging studies to review? ☐ Yes ☐ No

Review of Systems:

- ☐ Recent unexplained weight loss
- ☐ Hearing loss or ringing
- ☐ Fever
- ☐ Memory loss or confusion
- ☐ Shortness of breath
- ☐ Rash or itching
- ☐ Blood in stool
- ☐ Bleeding or bruising tendency
- ☐ Lightheadedness or dizziness
- ☐ Blurred or double vision
- ☐ Chest pain
- ☐ Nausea or vomiting
- ☐ Burning or painful urination

PRINT NAME: _____ DATE OF BIRTH: _____

TYPE OF INSURANCE: _____

PRIMARY CARE PHYSICIAN: _____ DATE: _____

For Clinical Use
Height: _____
Weight: _____

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