INNOVATIVE
SPINE CARE

10903 Sheldon Road • Tampa, FL 33626
Phone: 813-920-3022 • Fax 813-920-3002

www.GotSpinePain.com

(Please Print Clearly)

Patient Medical History

Name _____ DOB _____ Age ____ Date. _____

Height: _____ WC MVA (please circle) DOI/DOA: _____

What is the main reason you are here? _____

CURRENT MEDICATIONS (List all medications-use back of this sheet if you need more room)

MEDICATION	DOSAGE	#Per Day/Frequency	Reason for Taking (if known)

ARE YOU ALLERGIC TO ANY MEDICATION: YES NO If so, what? _____

PAST MEDICAL HITORY- Check all that apply

☐ Diabetes ☐ Asthma ☐ Hypo/Hyper Thyroid ☐ High Cholesterol	☐ High Blood Pressure ☐ Bronchitis or Emphysema ☐ Rheumatoid Arthritis	☐ Heart Desease ☐ Pneumonia ☐ Other:_____ ☐ History of Cancer ☐ type:_____	☐ Heart Attack ☐ Ulcers ☐ Blood Clots

PAST SURGICAL HITORY- Check all that apply

☐ Appendix ☐ (Appendectomy) ☐ Gall Bladder ☐ (Cholecystectomy) ☐ Heart Bypass	☐ Prostate ☐ Breast Surgery ☐ Back Surgery ☐ Total Joint ☐ Replacement	☐ Tonsillectomy ☐ Hysterectomy ☐ Arthroscopy	☐ Other:_____ ☐ _____ ☐ _____ ☐ _____ ☐ _____

Family Medical History

Has anyone in your immediate family died of heart disease: YES NO _____

Has anyone in your family had an adverse reaction to anesthesia: YES NO _____

Has anyone in your family had an adverse reaction to Latex: YES NO _____

List any medical illnesses that run in your family: _____

Social History

Who do you live with now: SPOUSE BY YOURSELF OTHER FAMILY FRIENDS OTHER _____

Do you smoke tobacco? YES NO How many?_____ packs per day How long? _____years

Do you drink alcohol? YES NO How many?_____ drinks per day How long? _____years

DO YOU NOW HAVE ANY PROBLEMS RELATED TO THE FOLLOWING?

Constitutional Symptom			Eyes			Allergic Ear/Nose/Throat			Genitourinary				
Fever	Y	N	Blurred Vision	Y	N	Hay Fever	Y	N	Ear Infection	Y	N	Urine Infection	Y N
Chills	Y	N	Double Vision	Y	N	Drug Allergies	Y	N	Sore Throat	Y	N	Painful Urination	Y N
Headache	Y	N	Pain	Y	N	Sinus Problem	Y	N	Urinary Frequency	Y	N		
Other	Y	N	Other _____			Other _____			Other _____			Other _____	

Gastrointestional			Neurological			Endocrine			Respiratory			Hemotologic/Lymphatic		
Abdominal Pain	Y	N	Tremors	Y	N	Excessive Thirst	Y	N	Frequent Cough	Y	N	Swollen Glands	Y	N
Nausea/Vomiting	Y	N	Dizzy Spells	Y	N	Too hot/cold	Y	N	Short of Breath	Y	N	Blood Clots	Y	N
Rectal Bleeding	Y	N	Numbness	Y	N	Tired/Sluggish	Y	N	Wheezing	Y	N	Bleeding Problem	Y	N

Cardiovascular			Integumentary			Musculoskeletal			Psychologic History			Other Medical Condition(s)
Chest Pain	Y	N	Skin Rash	Y	N	Joint Pain	Y	N	Depression	Y	N	_____
Varicose	Y	N	Boils	Y	N	Neck Pain	Y	N	Bipolar Disorder	Y	N	_____
High B.P.	Y	N	Persistent Itch	Y	N	Back Pain	Y	N	Schizophrenia	Y	N	_____
Other _____			Other _____			Other _____			Other _____			_____

Please use the back of this form if you need more room to write out your answers to any of the above questions