Institute of Spinal Disorders

Dear Patient,

Failure to produce the required paperwork and films from any prior testing <u>WILL</u> result in the rescheduling of your appointment.

In regard to your upcoming appointment with Dr. Myles. You will need the following:

- Completed new patient paperwork.
- Driver's license or photo ID.
- Insurance cards.
- Films for any prior imaging related to the body part we will be seeing you for (X-rays, MRI's, CT Scans, discograms, myelograms, etc.) and associated reports. Even if the referring doctor's office is to send these films and tests, we ask that you request your own copy to bring to the appointment to avoid rescheduling your appointment.
- Operative reports for any prior procedures related to the body part we will be seeing you for (EMG/NCV, Epidural Steroid injections, Facet Joint injections, Rhizotomy, etc.).

If your paperwork is NOT complete, please arrive 30 minutes prior to your scheduled appointment time. If your paperwork is complete, please arrive 15 minutes early.

Our **Hurst** office is located at 729 W. Bedford-Euless Rd. Ste 206. Hurst. TX 76053. Please call for directions

Our **Fort Worth** office is located at 3600 W. 7th St. Ft Worth,Tx 76107

You can reach us by calling 817-288-0084; our fax is 817-445-1039. If you need to cancel your appointment, please give us 24 hour notice or you could be charged $50.

Thank you!

Appointment date: _____ Appointment time: _____

Institute of Spinal Disorders

Please use BLUE or BLACK ink only to complete this form. Please print.

PATIENT INFORMATION

Date: _____

Last Name: _____ First Name: _____

Middle Name: _____

DOB: _____ Sex (circle one): Male Female

Marital Status (circle one): Married Single Divorced Widowed

Race: _____ Ethnicity: Hispanic Non-Hispanic

Preferred Language: _____

Email Address: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Address:_____

Employment status (circle one): Full Time Part Time Unemployed Retired Student Self Employed

Employer:_____ Phone Number: _____

Address: _____ City/ State/ Zip: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Contact Number: _____ Relationship: _____

IF PATIENT IS A MINOR

Guardian's Name: _____ DOB: _____

SSN: _____

How did you hear about our office?_____

Who is your primary care physician? _____

Phone Number:_____

What is the name of your pharmacy? _____

Phone Number:_____ City: _____

INSURANCE INFORMATION

Primary Insurance

Primary Insurance: _____

Address: _____City/State/Zip:_____

Insured's Name: _____ DOB: _____ SSN: _____

Insured's ID #: _____ Group # (required): _____

Relation: _____

Additional Insurance

Secondary Insurance: _____

Address: _____City/State/Zip: _____

Insured's Name: _____ DOB: _____SSN: _____

Insured's ID #: _____

Group # (required): _____ Relation:_____
_____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with the above listed Insurance Company(ies) and assign directly to THE INSTITUTE OF SPINAL DISORDERS all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance; I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. By my signature I consent to medical treatment by THE INSTITUTE OF SPINAL DISORDERS.

Responsible Party Signature: _____

Relationship: _____Date: _____

INSTITUTE OF SPINAL DISORDERS FINANCIAL POLICY

Thank you for choosing the INSTITUTE OF SPINAL DISORDERS for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding and acceptance of our patient financial policies.

The **patient** (or patient's legal guardian if a minor) is ultimately responsible for paying for the treatment and care that we deliver. We will file your insurance claims including most secondary insurances if you provide us with current and complete personal and insurance information.

We will verify insurance benefits before the **patient's** treatment and care begins. The **patient** is responsible for paying all co-pays, coinsurance, deductibles, surgery deposits and for all treatment and care not covered by the **patient's** insurance plan.

Co-pays are due at the time that the service is rendered. Payments for coinsurance, deductibles and for treatment and care that are not covered by the **patient's** insurance plan are due at the time services are rendered on the day of the appointment. The deductible/coinsurance for a recommended surgical treatment will be due at the time of the preop appointment for the procedure with the **patient's** insurer(s). The procedure will not be scheduled until the deductible/coinsurance has been paid or a payment arrangement has been approved and setup. The **patient** will be charged a fee of $35.00 for a returned check.

If a **patient's** claims are pended for information that must be received from the **patient** and the **patient** fails respond to the carrier within its allotted time frame, the **patient** will be held responsible for the balance in full. Examples of these situations are claims pended for accident details, co-ordination of benefit or a child's student status.

We will be happy to complete Disability forms or FMLA paperwork. However, this does require an appointment with our Physician Assistant, for paperwork to be completed. We will not Fax paperwork, it will be given to the patient at the appointment. The cost is $35 per Form.

ACKNOWLEDGEMENT AND ACCEPTANCE

By my signature below, I authorize assignment of my financial benefits to INSTITUE OF SPINAL DISORDERS and understand and agree that I am personally financially responsible for charges not covered by this assignment. I have read, understand and agree with the policies and terms listed above.

Patient Name (Printed): _____

Patient/Guardian Signature: _____

Date: _____

NOTICE OF PRIVACY POLICIES AND PRACTICES

Dear Patient,

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

At the Institute of Spinal Disorders, we are committed to treating and using protected health information about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information, it also describes your rights as they relate to your protected health information. This Notice is effective April 14,2013 and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION

Each time you visit the Institute of Spinal Disorders, a record of your visit is made. Typically, this record contains information about your visit including your examination, diagnosis, test results, treatment as well as other pertinent healthcare data. This information, often referred to as your health or medical record, serves as a:

- Means of communication with other health professionals involved in your care
- Legal document outlining and describing the care you received
- A tool that you, or another payer (your insurance company) will use to verify that services billed were actually provided
- An education tool for medical health providers
- A source for medical research
- Basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards
- A source of data for planning and/or marketing
- A tool that we can reference to ensure the highest quality of care and patient satisfaction

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individual.

YOUR RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice

OUR RESPONSIBILITIES

THE INSTITUTE OF SPINAL DISORDERS is required to:

- Maintain the privacy of your health information
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have regarding communication of health information via alternative means and locations

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to procedures included in the authorization.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION:

We will use your health information for treatment. Your health information may be used by staff members of disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, *an&* providing treatment. For example: results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted.

We will use your information for payment. Your health plan may request and receive information on dates of service, the services provided and the medical condition being

treated in order to pay for the service rendered to you.

We will use your information for regular health operations. Your health information may be used as necessary to support the day-to-day activities and management of THE INSTITUTE OF SPINAL DISORDERS. For example: information on *the* services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Business Associates. In some instances, we have contracted separate entities to provide services for us. These "associates" require your health information In order to accomplish the tasks that we ask them to provide. Some examples of these "business associates" might be a billing service, collection agency, answering services and computer software/hardware provider.

Communication with family. Due to the nature of our field, we will use our best judgment when disclosing health information to a family member, other relatives, or any person that is involved in your care or that you have authorized to receive this information. Please inform the practice when you do not wish a family member or other individual to have authorization to receive your information.

Research/Teaching/Training. We may use your information for the purpose of research, teaching and training.

Healthcare Oversight Federal law requires us to release your information to an appropriate health agency, public health authority or attorney, or other federal/state appointee if there are circumstances that require us to do so.

Public health reporting. Your health information may be disclosed to public health agencies as required by law.

Law enforcement Your health information may be disclosed to law enforcement agencies, without your permission to support government audits and inspections, facilitate law-enforcement investigations, and to comply with government mandated reporting.

Appointment reminder. The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are sent by mail in a closed envelope, or a brief non- specific message may be left on your answering machine. If you don't approve of these methods, or, if you prefer alternative methods please inform the practice.

Other uses and disclosures. Disclosure of your health information or its use for any purpose other than those listed about requires your specific written authorization. If you change your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have complaints, questions or would like additional information regarding this notice or the privacy practices of THE INSTITUTE OF SPINAL DISORDERS please contact:

INSTITUTE OF SPINAL DISORDERS
729 W. Bedford-Euless Rd. Suite #206
Hurst TX 76053
Phone: 817-288-0084
Fax: 817-445-1039

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Official, or, you may file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice's Privacy Official or with the Office for Civil Rights. The address for the Office for Civil Rights is listed below.

OFFICE FOR CIVIL RIGHTS
U.S. Department of Health and Human Service
200 Independence Avenue, S.W., Room 509F, HHH Building
Washington, D.C. 20201

By my signature below, l acknowledge that I have received the **NOTICE** OF PRIVACY POLICIES AND PRACTICES for Institute of Spinal Disorders.

Patient/Guardian signature: _____ Date: _____

Institute of Spinal Disorders

PRIVACY INFORMATION

Patient Name:_____

1. Please list **the** names of family **members or** other persons, if any, who we may inform about your general medical condition and your diagnoses:
   _____
   _____
   _____

2. Please list the names and phone numbers of family members or significant others, if any, whom we may inform about your **medical condition ONLY** IN AN EMERGENCY:
   _____
   _____
   _____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.
   _____
   _____
   _____

4.
5. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL": **YES** **NO**

6. Please print the telephone number, if any, where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number: (___)_____

7. Can confidential messages (i.e. appointment reminders) be left on your home answering machine or voicemail? **YES** **NO**

8. If you do not have voicemail, can a confidential message be left at your place of employment? **YES** **NO**

Patient/Guardian signature_____ Date:_____

Robert T. Myles, M.D.
729 W. Bedford-Euless Rd., Ste. 206
Hurst, Texas 76053
Phone: 817-288-0084 Fax # 817-445-1039

DISCLOSURE OF PHYSICIAN OWNERSHIP

Baylor Scott & White Medical Center-Trophy Club, Spinal Disorders, PLLC, Surgical and Diagnostic Center, LP, AHM and I are committed to providing clinical excellence in a safe, comfortable environment for you and your family members. I am an owner of all Medical Entities listed above in this letter. Having ownership in the companies listed above enables me to have a voice in the administration and policies of our hospital and Medical Services provided to you. This involvement helps me to ensure the highest quality of care to you and your loved ones.

Baylor Scott & White Medical Center-Trophy Club is a physician owned hospital and a list of the hospital's owners that are physicians is available upon your request.

Spinal Disorders, PLLC provides state of the art neuro-monitoring for your protection during surgical procedures.

Surgical and Diagnostic Center, LP is an outpatient surgery center that provides outpatient surgical treatment and care at a more economical cost than a large hospital.

American Healthcare Management (AHM) is a management company involved in the management of a surgery center.

If you have any questions concerning this notice, please feel free to ask Dr. Robert Myles or the Chief Executive Officer at Baylor Scott & White Medical Center-Trophy Club.

Patient name: _____

Patient signature: _____

Date: _____

Institute of Spinal Disorders

PAIN MANAGEMENT AGREEMENT

Your signature on this agreement means that you will follow all the terms below. It also is an understanding that you are to follow the plan of care and will not receive Opioid prescriptions from Dr. Robert Myles's office.

I understand that I am currently under the care of another doctor for my pain management or I will be referred to another doctor for my pain management. It is my responsibility to make appointments with my pain management doctor. I will not come to the Dr. Myles office or request by phone, prescription refills or new prescriptions from Dr. Robert Myles. This includes and is not limited to pain medication or other controlled substances. If I am unable to keep the appointments, decide to change pain management doctors or am terminated from my pain management doctor, I will not contact Dr. Robert Myles during this interim for refills or new prescriptions. I assume full responsibility for re-establishing pain management care. I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by all physicians involved in my care.

Patient name: _____

Patient signature: _____

Date: _____

Institute of Spinal Disorders

NO SHOW/CANCELLATION POLICY

Due to our schedule effective 05/13/2019, we will be charging a $50.00 fee for office visit NO SHOWS without a cancellation of at least 24 hours in advance.

If a LIVE interpreter is required for your visit and the appointment is cancelled less than 24 hours in advance, we will charge a fee of $116.00. We offer virtual interpreting services to avoid this fee. Virtual interpreting services are no cost to the patient if there is a cancellation less that 24 hours in advance but the $50.00 no show fee still applies.

We will be charging a $150.00 fee for no shows for surgical procedures and injections done at the hospital.

Thank you for your consideration in this matter.

Patient signature:_____

Date:_____

Institute of Spinal Disorders

729 W. Bedford-Euless Rd. Suite 206
Hurst, Texas 76053
Phone: 817-288-0084
Fax: 817-445-1039

NEW MEDICATION/ REFILL MEDICATION PROTOCOL

Dr. Robert T. Myles M.D.
Dovie McVean MS,PA-C

New:
If medications are needed, they will be given at the time of a new visit appointment. Please be sure to ask the physician if any prior medication should be continued or discontinued.

Refills:
Medication refills will be called in or faxed to your pharmacy within 72 hours of your request. No medication will be filled after clinic hours or during weekends. Please have your pharmacy fax all/any refills to the office prior to 3pm. Please do not continue to phone prior to 3pm for it will only delay your medication request.

Disclosure:
If discovered you are obtaining medication from more than one physician and/or pharmacy or you are abusing narcotic medication, you will be immediately dismissed from the practice at the physician's discretion. Should the physician choose to continue to see you as a patient, he may continue to treat your illness, though he will no longer prescribe narcotic medication. Lost or misplaced medications will not be replaced prior to their respective refill date unless a letter is supplied from the Police Department or Fire Department.

Patient Name:_____ Date:_____

Patient Signature:_____

General Health Questionaire

Did you know that heart disease is the largest killer of American men and women?

***** 50% of men and 63% of women who died suddenly of Coronary Heart Disease had no previous symptoms of the disease.*****

***** 1 in every 2.4 women's deaths is from cardiovascular disease compared to 1 in 24 from breast cancer.*****

Please indicate whether you have ever had a significant problem with any of the symptoms or conditions listed below.

Your physician may recommend a diagnostic test to determine the cause of your symptoms.

Patient Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____ **Male / Female**

1. Circle YES if you are over 40 and have NOT had a stress test	**YES / NO**
2. Do you have a family history of heart disease or stroke?	**YES / NO**
3. Do you experience shortness of breath at rest or during exertion?	**YES / NO**
4. Do you experience chest pain, tightness, pressure, or discomfort?	**YES / NO**
5. Have you ever had a previous blood clot?	**YES / NO**
6. Have you ever been told you have diabetes or a problem with high blood sugar?	**YES / NO**
7. Do you have high blood pressure?	**YES / NO**
8. Do you currently smoke or have a history of smoking?	**YES / NO**
9. Do you have asthma, exercise induced asthma, COPD, emphysema, a persistent cough or chronic bronchitis?	**YES / NO**
10. Have you been diagnosed with sleep apnea?	**YES / NO**
11. Have you ever had any episodes of dizziness or fainting?	**YES / NO**
12. Have you ever had an abnormal EKG?	**YES / NO**
13. Do you have any Metabolic or Thyroid disorders?	**YES / NO**
14. Do you ever have numbness, tingling, or pain in your arms or legs?	**YES / NO**
15. Do you ever have pain or swelling in your limbs?	**YES / NO**

Institute of Spinal Disorders

BONE HEALTH QUESTIONNAIRE

Name: _____ DOB: _____ Date: _____

1. Do you have a family history of had any of the following as an adult: YES NO
   - Spinal Fracture
   - Hip Fracture
   - Osteoporosis
   - Wrist Fractures
2. Have you ever taken any of the following medications longer than 3 months at any time in your life? YES NO
   - Prednisone/Methylprednisone
   - Anti-seizure medication (Dilantin,Depakote, etc)
   - Rheumatoid Arthritis medication
   - Medications for GERD or Heartburn
   - Testosterone Supplementation
3. Have you ever taken or has anyone ever suggested that you take a bone medication? YES NO
   Brand names: Fozamax, Boniva, Actonel, Reclast, Prolia or Forteo
4. Have you ever had any of the following surgeries? YES NO
   - Gastric Bypass
   - Gastric banding
   - Lap band or sleeve
   - Colon or small bowel resection
5. Have you had a bone density test (DEXA) in the last 2 years? YES NO
   - Where
   - When

ROVIDER USE ONLY;
E/M code with Modifier -24 - Post Op
Schedule with Bone Health Clinic Review and Appointment Not Needed

Name: _____

Institute of Spinal Disorders

Robert Myles, M.D.

HISTORY FORM

DATE: _____

NAME: _____ **AGE**: _____ **SEX**: _____

HEIGHT: _____

WHERE IS YOUR PAIN LOCATED?

Neck pain only	R	L	Both
Neck and shoulder pain	R	L	Both
Neck/ shoulder/ and arm pain	R	L	Both
Arm pain only	R	L	Both
Thoracic pain only	R	L	Both
Thoracic and rib/abdominal pain	R	L	Both
Low back pain only	R	L	Both
Low back and hip/ buttock pain	R	L	Both
Low back and hip/ buttock/ leg pain	R	L	Both
Low back and leg pain	R	L	Both
Leg pain only	R	L	Both
Other:			

IF YOU CIRCLED YES TO LOW BACK AND HIP/ BUTTOCK/ LEG PAIN, WHICH HURTS WORSE? (Circle one)

Low back Hip/ Buttock Leg

IF YOU CIRCLED YES TO NECK AND SHOULDER/ ARM PAIN, WHICH HURTS WORSE? (Circle one)

Neck Shoulder Arm

Name: _____

WHAT CAUSED YOUR PAIN? (Circle one)

Unsure Fall Motor Vehicle Accident Altercation
Lifting Twisting Bending Other: _____

HOW WOULD YOU DESCRIBE YOUR PAIN? (Circle all that apply)

Sharp Burning Stabbing Aching Shooting Knife-like Other: ___

WHEN DOES YOUR PAIN OCCUR? (Circle all that apply)

Constantly With Activity Daily Weekly
Monthly Occasionally

DOES THE PAIN RADIATE INTO YOUR ARMS OR LEGS WHEN YOU COUGH, SNEEZE, OR STRAIN FROM A BOWL MOVEMENT? Yes No

DOES THE PAIN WAKE YOU UP AT NIGHT? Yes No

ON A SCALE OF 0-10 HOW WOULD YOU RATE YOUR PAIN?
(0= no pain, 10= severe pain)

Overall: ____ With activity: ____ Without activity: ____

WHAT MAKES YOUR PAIN WORSE? (Circle all that apply)

Walking Sitting Standing Lifting Typing
Writing Reaching Riding in a car Twisting
Other: _____

IF YOU ANSWERED THAT WALKING OR STANDING INCREASES YOUR PAIN, DOES THAT PAIN RADIATE TO YOUR LEGS? Yes No

HOW DO YOU MAKE YOU PAIN GO AWAY?

Sit Stand Lay down Other: _____

Name: _____

HAVE YOU EVER BEEN INVOLVED IN PHYSICAL THERAPY FOR YOUR CURRENT PAIN?

Yes No

If you answered yes, are you still involved?

Yes How long have you been attending? _____

No How long did you attend and when was your last session? _____

_____

What treatments did you have in physical therapy? (Circle all that apply)

Heat/ cold pack Massage Ultrasound Back Exercises

Neck exercises Chiropractic manipulations or adjustments

Pool therapy

Did therapy help your pain? No Mildly Moderately Complete relief

Name: _____

HAVE YOU HAD ANY OF THE FOLLOWING TESTS PERFORMED FOR YOUR CURRENT PAIN?

Test	Date(s) performed
MRI	
CT	
Myelogram	
Discogram	
EMG/ NCS	
Other:	

HAVE YOU TRIED ANY OF THE FOLLOWING TREATMENTS FOR YOUR CURRENT PAIN? (Please leave blank if not applicable)

Treatment	Date(s) performed	Did you experience any relief? (Yes or No)
Facet joint injection		
Trigger point injection		
Epidural steroid injection		
Rhizotomy		

Medication	Did you experience any relief? (Yes or No)
Anti-inflammatories	
Oral steroids	

ARE YOU ALLERGIC TO ANY DRUGS?

No Yes Medication name: Reaction:

_____ _____
_____ _____
_____ _____
_____ _____

PLEASE LIST ANY CURRENT MEDICATIONS YOU ARE TAKING

_____
_____
_____
_____

Name: _____

DO YOU HAVE ANY OF THE FOLLOWING PAST MEDICAL ILLINESSES? (Circle all that apply)

Diabetes	Y	N	Tuberculosis	Y	N
High blood pressure	Y	N	Fibromyalgia	Y	N
Angina	Y	N	Glaucoma	Y	N
Heart attack	Y	N	Anemia	Y	N
Kidney disease	Y	N	Bleeding problems	Y	N
Stomach ulcers	Y	N	Rheumatoid arthritis	Y	N
Osteoarthritis	Y	N	Chest Pain	Y	N
Osteoporosis	Y	N	Emphysema	Y	N
Blood clots in legs	Y	N	Migraine headaches	Y	N
Cancer (WHAT TYPE)	Y	N	Lupus	Y	N
Hepatitis	Y	N	Ulcerative colitis	Y	N
Asthma	Y	N	Crohn's disease	Y	N
Epilepsy	Y	N	Depression	Y	N
Thyroid Disease	Y	N	Anxiety	Y	N
Jaundice	Y	N	Attention Deficit disorder	Y	N
AIDS/HIV	Y	N	Obsessive Compulsive disorder	Y	N
Stroke	Y	N	Bipolar Disorder	Y	N
Other (please list):					

HAVE YOU HAD ANY OF THE FOLLOW SURGERIES? (Circle all that apply, please include the date of your surgery), (C= cervical, T= thoracic, and L= lumbar)

Laminectomy C T L	Y	N	Hip replacement	Y	N
Discectomy C T L	Y	N	Carpal tunnel release	Y	N
Lumbar spinal fusion	Y	N	Foot surgery	Y	N
Cervical spinal fusion	Y	N	Fracture repair	Y	N
Thoracic spinal fusion	Y	N	Hysterectomy	Y	N
Abdominal surgery	Y	N	Shoulder	Y	N
Cardiac stent placement	Y	N	Hernia repair	Y	N
Heart surgery	Y	N	Cubital tunnel release	Y	N
Gall bladder	Y	N	Knee replacement	Y	N
C – section	Y	N	Knee surgery	Y	N
Hip surgery	Y	N	Other (please list):		
Appendectomy	Y	N			

Name: _____

SOCIAL HISTORY

Do you smoke?	Y	N	Number of packs per day? _____ How long have you smoked for? _____		
Do you chew tobacco?	Y	N	How much per day? _____ How long have you chewed tobacco for? _____		
Do you drink alcohol?	Y	N	How much do you drink? _____ How often do you drink? _____		
Do you use illegal	Y	N	Explain:		
Married	Y	N	Single	Y	N
What is your occupation?					

FAMILY HISTORY

	Mother	Father	Siblings
Alive (yes or no)			
Age			
Back problems			
Diabetes			
Heart Disease			
Thyroid Disease			
CVA			
High Blood Pressure			
Lung Disease			
Cirrhosis			
Cancer (what type?)			
Other (please list)			

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING LATELY? (Circle all that apply)

Fever	Y	N	Night sweats	Y	N
Chills	Y	N	Other (please list):		
Sudden loss of bladder/ bowel control	Y	N			
Weight loss	Y	N			