

HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

Who referred you to us? _____

Occupation: _____ Primary Care Provider: _____

Is this a: Workman's Comp Claim or Motor Vehicle Accident Do you have a lawyer for this injury? Yes No

Is English your primary language? Yes No If no, which language? _____

IN THE PAST 2 WEEKS, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Check all that apply)

<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Involuntary Weight Loss	<input type="checkbox"/> Headache	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Visual Difficulty
<input type="checkbox"/> Ringing In Ear	<input type="checkbox"/> Seizures/Tremors	<input type="checkbox"/> Sinus Congestion	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Wheeze/Cough	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Stomach Pain
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Rash	<input type="checkbox"/> Blood In Urine/Stool	<input type="checkbox"/> Easy Bruising
<input type="checkbox"/> Joint Pain/Swelling	<input type="checkbox"/> Swelling	<input type="checkbox"/> Excessive Thirst/Appetite	<input type="checkbox"/> Fainting
<input type="checkbox"/> Recent Bleeding	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Loss of Bowel/Bladder Control	<input type="checkbox"/> Hearing Loss

PAIN HISTORY

Date of onset of present pain (date of injury or accident): _____

CAUSE OF PAIN:

<input type="checkbox"/> Motor Vehicle Accident	<input type="checkbox"/> Accident at Work	<input type="checkbox"/> Accident Away from Work	<input type="checkbox"/> Sports
<input type="checkbox"/> Unknown Cause	<input type="checkbox"/> Other: _____		

PAIN LOCATION:

<input type="checkbox"/> Left Side	<input type="checkbox"/> Right Side	<input type="checkbox"/> Both Sides		
<input type="checkbox"/> Headache	<input type="checkbox"/> Neck	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Leg/Foot	<input type="checkbox"/> Arm/Hand
<input type="checkbox"/> Chest	<input type="checkbox"/> Upper Back	<input type="checkbox"/> Mid Back	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Low Back
<input type="checkbox"/> Buttock	<input type="checkbox"/> Other: _____			

PAIN QUALITY:

<input type="checkbox"/> Burning	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Aching	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Numbness
<input type="checkbox"/> Tingling	<input type="checkbox"/> Weakness	<input type="checkbox"/> Shooting	<input type="checkbox"/> Dull	<input type="checkbox"/> Sharp
<input type="checkbox"/> Other: _____				

PAIN DURATION:

<input type="checkbox"/> Occasional	<input type="checkbox"/> Off and On	<input type="checkbox"/> Quick/Shooting	<input type="checkbox"/> Frequent	<input type="checkbox"/> Daily	<input type="checkbox"/> Constant
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ACTIVITIES THAT MAKE PAIN WORSE:

<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing	<input type="checkbox"/> Walking	<input type="checkbox"/> Bending Forward
<input type="checkbox"/> Arching Backwards	<input type="checkbox"/> Rotational Movement	<input type="checkbox"/> Driving	<input type="checkbox"/> Rest/Sleep

TIMES OF PAIN:

<input type="checkbox"/> In The Morning	<input type="checkbox"/> In The Evening	<input type="checkbox"/> With Certain Movements	<input type="checkbox"/> During Rest	<input type="checkbox"/> During of After Activity
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ACTIVITIES THAT MAKE PAIN BETTER:

<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing	<input type="checkbox"/> Walking	<input type="checkbox"/> Movement
<input type="checkbox"/> Lying Down	<input type="checkbox"/> Leaning Forward	<input type="checkbox"/> Leaning Back	<input type="checkbox"/> Heat
<input type="checkbox"/> Ice	<input type="checkbox"/> Rest	<input type="checkbox"/> Other: _____	

SPINAL DIAGNOSTICS

Robert D. Heros, M.D. * Jason G. Anderson, D.O.
Vishal Khemlani, M.D. * Heather L. Marsh, PA-C

Patient Name: _____ Date of Birth: _____

Height: _____ Weight : _____

DO YOU HAVE A SIGNIFICANT HISTORY OR CURRENTLY HAVE:

Y	N	NEURO	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	Last: _____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	Date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	
<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Weakness/Paralysis	
<input type="checkbox"/>	<input type="checkbox"/>	Bell's Palsy/Parkinson's	Dementia YES NO

Neurologist: _____

Ophthalmologist: _____

Y	N	CARDIOVASCULAR	
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack (MI)	Date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain (Angina)	
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Rate/Rhythm/Pacemaker	
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder: (specify)	
<input type="checkbox"/>	<input type="checkbox"/>	Anticoagulant Treatment	

Cardiologist: _____

Anticoagulant Management: _____

Y	N	RESPIRATORY	
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma or Wheezing/Inhaler	
<input type="checkbox"/>	<input type="checkbox"/>	Snoring/Sleep Apnea/Difficult Airway	
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/COPD	
<input type="checkbox"/>	<input type="checkbox"/>	Chronic/Frequent Bronchitis or Pneumonia	
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis (TB)	

Pulmonologist: _____

Y	N	LIFESTYLE		
<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke?	# years smoked:	# packs per day:
<input type="checkbox"/>	<input type="checkbox"/>	Former Smoker, year you quit?		
<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol?	Drinks/week:	
<input type="checkbox"/>	<input type="checkbox"/>	Treated for drug/alcohol dependency?		
<input type="checkbox"/>	<input type="checkbox"/>	Currently pregnant?		
<input type="checkbox"/>	<input type="checkbox"/>	Date of your last period:		
<input type="checkbox"/>	<input type="checkbox"/>	[] Menopause [] Hysterectomy		

Y	N	SKIN	
<input type="checkbox"/>	<input type="checkbox"/>	Open Wounds/Breaks in Skin	
<input type="checkbox"/>	<input type="checkbox"/>	Rashes	
<input type="checkbox"/>	<input type="checkbox"/>	History of Cold Sores/Shingles/Herpes	

Dermatologist: _____

Y	N	GASTROINTESTINAL/GENITOURINARY	
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/GERD/Reflux/Hiatal Hernia	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease: (specify)	
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Liver Function	
<input type="checkbox"/>	<input type="checkbox"/>	Colitis/Other Abdominal Problems	

Gastroenterologist: _____

Nephrologist: _____

Y	N	ENDOCRINE/IMMUNE SYSTEM	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetic: [] Type 1 [] Type 2	Avg AM level: _____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	

Endocrinologist: _____

Y	N	MUSCLE/SKELETAL	
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	
<input type="checkbox"/>	<input type="checkbox"/>	Use of a Cane/ Wheelchair/Walker	

Y	N	OTHER	
<input type="checkbox"/>	<input type="checkbox"/>	MRSA Infection	Date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Chemo: (specify)	

Oncologist: _____

<input type="checkbox"/>	<input type="checkbox"/>	Serious problems with any prior anesthetics	
<input type="checkbox"/>	<input type="checkbox"/>	Family history with serious anesthesia problems	
<input type="checkbox"/>	<input type="checkbox"/>	Infection/Illness in past 6 months:	
<input type="checkbox"/>	<input type="checkbox"/>	Current, or Date Resolved: _____	

Other medical problems or comments: _____

When was your last vaccination/flu shot? _____

OFFICE USE ONLY

Patient Initials: _____	Date: _____	Patient Initials: _____	Date: _____
Patient Initials: _____	Date: _____	Patient Initials: _____	Date: _____
Patient Initials: _____	Date: _____	Patient Initials: _____	Date: _____

SPINAL DIAGNOSTICS

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Patient Name: _____ Date of Birth: _____

PREVIOUS TREATMENTS FOR THIS PAIN

PHYSICAL THERAPY

<input type="checkbox"/> Never Tried	<input type="checkbox"/> Not Helpful	<input type="checkbox"/> Minimally Helpful	<input type="checkbox"/> Somewhat Helpful	<input type="checkbox"/> Helpful
Where? _____		How long/Last Treatment: _____		

CHIROPRACTIC CARE

<input type="checkbox"/> Never Tried	<input type="checkbox"/> Not Helpful	<input type="checkbox"/> Minimally Helpful	<input type="checkbox"/> Somewhat Helpful	<input type="checkbox"/> Helpful
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MASSAGE

<input type="checkbox"/> Never Tried	<input type="checkbox"/> Not Helpful	<input type="checkbox"/> Minimally Helpful	<input type="checkbox"/> Somewhat Helpful	<input type="checkbox"/> Helpful
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ACUPUNCTURE

<input type="checkbox"/> Never Tried	<input type="checkbox"/> Not Helpful	<input type="checkbox"/> Minimally Helpful	<input type="checkbox"/> Somewhat Helpful	<input type="checkbox"/> Helpful
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SPINE INJECTIONS

<input type="checkbox"/> Never Tried	<input type="checkbox"/> Not Helpful	<input type="checkbox"/> Minimally Helpful	<input type="checkbox"/> Somewhat Helpful	<input type="checkbox"/> Helpful
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SPINE SURGERY

<input type="checkbox"/> Never Tried	<input type="checkbox"/> Not Helpful	<input type="checkbox"/> Minimally Helpful	<input type="checkbox"/> Somewhat Helpful	<input type="checkbox"/> Helpful
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MEDICATIONS/OTC PAIN MEDS

<input type="checkbox"/> Never Tried	<input type="checkbox"/> Not Helpful	<input type="checkbox"/> Minimally Helpful	<input type="checkbox"/> Somewhat Helpful	<input type="checkbox"/> Helpful
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DIAGNOSTIC IMAGING

MRI	Where: _____	Approx Date: _____
CT	Where: _____	Approx Date: _____
XRAY	Where: _____	Approx Date: _____

MEDICATIONS

PREVIOUS SURGERIES

MEDICATION NAME	SURGERY	YEAR
Please list all current prescription and over-the counter medications.		

Preferred Pharmacy: _____ City: _____ Phone: _____

ALLERGIES:

Please list ALL medication allergies

<input type="checkbox"/> No known drug allergies	<input type="checkbox"/> Tape/Adhesives	<input type="checkbox"/> Latex	<input type="checkbox"/> Iodine/Contrast Dye	<input type="checkbox"/> Shellfish
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Substance	Reaction (Itching, rash, breathing difficulties, etc.)