INDIANA SPINE CENTER

First in the State. Finest in the Field.

A UNITY HEALTHCARE PARTNER

PATIENT MEDICAL HISTORY

Patient Name_____ Date of Birth_____

Family Doctor/Primary Care Physician_____ Physician referring you to this clinic_____

Type of injury_____ Part of body affected_____

Date of injury/illness_____ Doctor seen:_____Date_____

Describe how the injury/illness occurred _____

_____

Which Pharmacy to you prefer to use?_____

Past Medical History	**YES**	**NO**	
1. Have you ever had surgery?	☐	☐	Reason:_____
2. Have you ever been hospitalized for a medical condition other than surgery? (Women, please include pregnancies)	☐	☐	Reason:_____ _____ _____
3. Do you take any medication on a regular basis? (Please include over the counter medications. Women, please include oral contraceptives)	☐	☐	Please list:_____ _____ _____
4. Do you have any allergies? (Include drugs, food, type)	☐	☐	Please list:_____ _____
5. Are you currently employed?	☐	☐	Occupation:_____
Social History			
6. Do you use tobacco products?	☐	☐	How often/amount:_____
7. Have you ever used tobacco products?	☐	☐	If yes, when did you stop?_____
8. Do you consume alcohol?	☐	☐	If so, how much?_____
9. Do you live alone?	☐	☐	
10. Women, chance you could be pregnant?	☐	☐	

Review of System

Have you ever had any of the following?

	Yes	No		Yes	No		Yes	No
Lung problems	☐	☐	Arthritis	☐	☐	Bladder/Urinary problems	☐	☐
High blood pressure	☐	☐	Depression	☐	☐	Stomach/Bowel problems	☐	☐
Kidney problems	☐	☐	Heart Disease	☐	☐	Thrombophlebitis/Blood clots	☐	☐
Thyroid disease	☐	☐	Diabetes	☐	☐	Fracture/Broken bone	☐	☐
Bleeding tendency	☐	☐	Gout	☐	☐	Other:_____ Where:_____		

Do you have a family history of the following?

Heart disease	☐	☐	Cancer	☐	☐	Bleeding tendencies	☐	☐
Arthritis	☐	☐	Diabetes	☐	☐	Other:_____		

Additional Comments:_____

_____

Date_____ SIGNATURE_____

Thank You