

Spine Surgery – New Patient History Form

Name: _____ Birthdate: _____ Today's Date: _____ Who referred you? _____

Are you being seen for your neck or back?: _____ How long have you had the symptoms? _____

If there was an injury, please describe it? _____

Date of injury: _____ Was this a work injury? (Yes/No)

Where is the worst area of pain? _____

Is there radiation to the arms? _____ Legs? _____

Is there numbness or tingling (where?) _____

Is there any weakness (if so, what)? _____

	Had it?	How long did it help?		Had it?	How long did it help?
Oral steroids			Massage therapy		
Epidural steroids			Acupuncture		
Facet injections			Brace		
Physical therapy			Anti-inflammatory		
Chiropractic care			Other		

Have you had spine surgery in the past? (Give dates, location, what was done) _____

Past Medical History (Circle or list all medical conditions for which you see a physician)

Heart Attack Angina High Cholesterol Cancer Diabetes Seizure Stroke Liver Disease
Asthma COPD Emphysema Stomach Ulcers High Blood Pressure Gout Hepatitis Kidney
Stones Blood Clot(s) Thyroid Disease Circulation Problems Aspirin Use AIDS/HIV

List any other condition for which you see a physician in the space below:

1.	2.	3.
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Past Surgical History (List all past surgeries and the date/place/surgeon to the best of your knowledge)

1.	5.
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2.	6.
3.	7.
4.	8.

Medications

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

Allergies (List medication to which you are allergic and the reaction you had)

1.	3.	5.
2.	4.	6.

Social History Do you smoke (Yes/No)? How many packs per day? _____

Occupation: _____

Review of Systems (Circle any of the following problems you **presently** have)

Constitutional: Fever Weight loss Fatigue Nausea/Vomiting

Eyes: Double Vision Blurred Vision Glasses Contact Lenses Implants

ENT & Mouth: Hearing Problems Sinus Trouble Dental Problems Hoarseness

CV: Chest Pain Palpitations Irregular Heartbeat Varicose Veins High Blood Pressure

Respiratory: Shortness of Breath Trouble Breathing at Night Coughing Wheezing

GI: Loss of Appetite Diarrhea Constipation Abdominal Pain Heartburn Jaundice

GU: Loss of Bladder Control Painful Urination Trouble Urinating

MS: Pain in Joints or Bones Swelling of Joints Arthritis Stiffness

Skin-Breast: Rashes Lesions Scars Masses/Lumps Skin Ulcers

Neuro: Headaches Memory Loss Weakness Balance Problems

Psych: Depression Hallucinations Sleep Disturbances Anxiety

Endocrine: Frequent Urination Frequent Thirst Hyperactivity/Hypoactivity Hair or Growth Change

Hematologic/Lymphatic: Bleeding Tendency Lymph Node Pain or Enlargement Anemia Clotting disorder

Allergic/Immunologic: Dermatitis Eczema Latex or Other Allergy