



A Multidisciplinary Approach to Back and Neck Care

Orthopedic Spine Surgery
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Patient Medical History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_ Height \_\_\_\_ Weight \_\_\_\_ Right Handed \_\_\_\_ Left Handed

Are you claustrophobic (you do not like confined spaces)? \_\_\_\_ Yes \_\_\_\_ No Age: \_\_\_\_

Referring Doctor: \_\_\_\_\_ Primary Care Doctor: \_\_\_\_\_

Complaint: \_\_\_\_\_

Current Medications: \_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

ALLERGY to Medications: \_\_\_\_\_

Surgical History: \_\_\_\_\_

Medical History: Have YOU had any of the following? Please check all that apply.

- Arthritis, Stroke, Cancer, Seizures, Poor Circulation, Heart Problems, Lung Problems, Thyroid Problems, Ulcer/Stomach Problems, Colon Problems, Diabetes, High Blood Pressure

Social History:

Do you smoke cigarettes? \_\_\_\_ How many packs a day? \_\_\_\_ How long have you smoked? \_\_\_\_

Do you drink Alcohol (wine, beer, mixed drinks)? \_\_\_\_ How often? \_\_\_\_\_

Family History: Any immediate family members with any of the following? Check all that apply.

- Arthritis, Stroke, Cancer, Seizures, Poor Circulation, Heart Problems, Lung Problems, Thyroid Problems, Ulcer/Stomach Problems, Colon Problems, Diabetes, High Blood Pressure

Review: Have YOU had any recent problems with the following? Check all that apply:

- Eyes, Ears, Nose, Throat, Bleeding/ Bruising / Swollen Glands, Numbness / Weakness / Confusion, Mouth, Thyroid, Urination, Breathing, Fever, Depression, Sexual Function, Stomach Pains / Constipation / Diarrhea, Weight change (Over 10 pounds), Allergy to foods / chemicals, Skin / Rashes, Bone / Muscle / Joints, Chest Pains / Palpitations

Have you ever had any of the following?

- CT scan - If YES, When \_\_\_\_ Where? \_\_\_\_
MRI scan - If YES, When \_\_\_\_ Where? \_\_\_\_
EMG scan - If YES, When \_\_\_\_ Where? \_\_\_\_
Myelogram - If YES, When \_\_\_\_ Where? \_\_\_\_
Spine Xrays - If YES, When \_\_\_\_ Where? \_\_\_\_