



Orthopaedic Spinal Surgery
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Nurse Practitioners
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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 | ____ Poor Circulation | ____ Ulcer/Stomach Problems |
| ____ Stroke | ____ Heart Problems | ____ Colon Problems |
| ____ Cancer | ____ Lung Problems | ____ Diabetes |
| ____ Seizures | ____ Thyroid Problems | ____ 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 | ____ Poor Circulation | ____ Ulcer/Stomach Problems |
| ____ Stroke | ____ Heart Problems | ____ Colon Problems |
| ____ Cancer | ____ Lung Problems | ____ Diabetes |
| ____ Seizures | ____ Thyroid Problems | ____ High Blood Pressure |

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

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

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? _____