Center for Spine and Orthopedics

Health History Form

Welcome to our office. We value maintaining a current medical record in order to provide you with quality patient care. Please review and answer all questions below. Your healthcare provider may have additional questions based on your responses and may ask you to fill out additional information if necessary. Thank you.

Patient name:_____

Age:_____ Date of Birth:_____

Height_____ Weight: _____ Male Female

Preferred pharmacy:_____ address: _____ phone:_____

PAST/ CURRENT MEDICAL HISTORY (Circle all that apply) **Comments**

Do you have a bleeding disorder? Yes No _____

Are you currently pregnant or believe that you may be pregnant Yes No

Have you been diagnosed with any of the below?

Anemia	Yes	No	High Blood Pressure	Yes	No
HIV AIDS	Yes	No	High Cholesterol	Yes	No
Aneurysm	Yes	No	Hypoglycemia	Yes	No
Anxiety disorder	Yes	No	Kidney Disease / Stones	Yes	No
Arthritis	Yes	No	Leg or Foot Ulcers	Yes	No
Asthma	Yes	No	Liver Disease	Yes	No
Bleeding Disorder	Yes	No	Lung Disease	Yes	No
Blood Clots (leg or lung)	Yes	No	Migraines	Yes	No
Cancer and type	Yes	No	MRSA/skin infections	Yes	No
Circulation Problems	Yes	No	Osteoporosis	Yes	No
Coronary Artery disease	Yes	No	Pacemaker	Yes	No
Depression	Yes	No	Prostate Disease	Yes	No
Diabetes	Yes	No	Pulmonary Embolism	Yes	No
Fibromyalgia	Yes	No	Rheumatoid Arthritis	Yes	No
Foot Ulcers	Yes	No	Seizures / Epilepsy	Yes	No
GERD/Reflux	Yes	No	Sleep Apnea	Yes	No
Gout	Yes	No	Stomach Ulcers	Yes	No
Head Injury	Yes	No	Stroke/TIA	Yes	No
Heart Attack (MI)	Yes	No	Thyroid Problems	Yes	No
Heart Disease	Yes	No	Tuberculosis	Yes	No
Hepatitis	Yes	No	Urinary Tract Infections	Yes	No

Other / Comments_____

_____

LIST CURRENT MEDICATIONS AND DOSES (Please include over the counter, vitamins and supplements)

_____ _____

_____ _____

ALLERGIES AND ADVERSE REACTIONS to medications, contrast dyes used in diagnostic tests, or Latex? Please list allergy and reaction. (IF NONE WRITE NONE)

ALLERGY REACTION

_____ _____

_____ _____

FAMIILY MEDICAL HISTORY		Relationship to you			Relationship to you
Alcohol abuse	Yes No	_____	Heart Attack	Yes No	_____
Asthma	Yes No	_____	High Blood Pressure	Yes No	_____
Anxiety	Yes No	_____	High Cholesterol	Yes No	_____
Back Problems	Yes No	_____	Kidney Disease	Yes No	_____
Bleeding Disorder	Yes No	_____	Liver Disease	Yes No	_____
Cancer	Yes No	_____	Osteoporosis	Yes No	_____
Depression	Yes No	_____	Scoliosis	Yes No	_____
Diabetes	Yes No	_____	Sick Cell Anemia	Yes No	_____
Epilepsy/Seizures	Yes No	_____	Stroke	Yes No	_____
Glaucoma	Yes No	_____	Thyroid Problem	Yes No	_____
Gout	Yes No	_____	Tuberculosis	Yes No	_____

Other:_____

PAST SURGICAL HISTORY (Please list all surgeries/procedures and dates that you have had since childhood and indicate left or right when appropriate)

_____
_____
_____
_____
_____
_____
_____

SOCIAL HISTORY

Occupation_____
Smoking Status □ Never □ Former □ Current everyday □ Current somedays
Have smoked since what age? _____
Smoking / How much? _____
Chewing Tobacco □ Yes □ No
Alcohol Intake □ None □ Yes, how much _____type of alcohol_____
Caffeine Intake □ None □ Yes, how many cups a day _____
Illicit Drugs □ Yes □ No If yes what type:_____
Do you use Medical Marijuana □ Yes □ No How much_____
Do you use Recreational Marijuana □ Yes □ No How much_____
Have you ever been treated for drug, alcohol or prescription abuse in the past? □ Yes □ No
Exercise Level □ Never □ Yes what type and how often
_____
Hand Dominance □ Right □ Left □ Both
Education:_____
Live alone or with others? □ Live Alone □ With Others □ Married □ Single □ Divorced □ Child
Is this an accident related injury?
Work related injury? □ Yes □ No
Auto related injury? □ Yes □ No
If injured, is litigation ongoing? □ Yes □ No

Chief Complaint/ History of Present illness:
What are you being seen for today? _____
Left_____Right_____N/A_____
Is it due to an injury? Yes No Were you hurt at work? Yes No Were you in a car accident? Yes No
How long has your problem or pain been present?_____
Date of injury?_____

Previous Health care providers you have seen for this problem?
_____

Injury / Pain to? Left Right Both
Arm Shoulder Elbow Wrist Hand Leg Knee Ankle Foot Neck Back
Other_____

How did your pain begin?
□ Abruptly, getting better □ Gradually, getting better
□ Abruptly, remaining the same □ Gradually, remaining the same
□ Abruptly, and getting worse □ Gradually, getting worse

Which best describes the quality of your current pain complaint (check all that apply)
□ Sharp □ Burning □ Throbbing □ Shooting □ Aching □ Stabbing □ Dull □ Numb □Tingling
Other_____

How often do you have pain?
□ Constantly □ Intermittently(several times per day)
□ Occasionally(several times per week) □ Rarely(a few times per month)

What makes your pain WORSE (check all that apply)?
□ Sitting □ Coughing □ Sneezing □ Looking up
□ Lifting □ Twisting □ Bending Forward □ Looking down
□ Standing □ Walking □ Bending Backward □ Weather Changes
□ Lying down □ Exercise □ Stress □ Bowel movements
□ Looking over your shoulder(R or L)
□ Other_____

What makes your pain BETTER (check all that apply)?
□ Standing □ Lying down □ Heat
□ Sitting □ Cold □ Nothing
□ Exercise/activity □ Rest
□ Medications- if yes which one(s):_____
□ Other:_____
□ Nothing

Is your pain associated with other symptoms?
□ Weakness – if yes, where?_____
□ Numbness – if yes, where?_____
□ Bowel or bladder changes – if yes describe:_____
□ Fine motor control problems(ie. Buttoning your shirt, using a pencil, etc)
□ Other:_____

Please check off any of the following treatments that you have had for your current symptoms:

Treatment	**Did it help (yes / no)?**		**Treatment**	**Did it help (yes / no)?**	
□Physical therapy	Yes	No	□Psychiatric Care	Yes	No
□Chiropractic care or manipulations	Yes	No	□TENS Unit	Yes	No
□Psychological Care	Yes	No	□Accupuncture	Yes	No
□Pain Program / Pain Clinic	Yes	No	Other:_____		
□ Medications					

Patient name:_____

REVIEW OF SYSTEMS (Please check symptoms you are having today)

CONSTITUTIONAL: □ no problem
□ poor appetite □ weight loss Amount_____ □ weight gain Amount_____ □ fevers □ night sweats

□ other _____

EYES: □ No problem
□ visual changes □ double vision □ color vision changes □ eye irritation □ other_____

EAR, NOSE, THROAT: □ No problem
□ hearing loss □ ringing in ears □ nosebleeds □ other _____

CARDIOVASCULAR: □ no problem
□ chest pain □ swelling in legs/feet □ palpitations □ fainting □ shortness of breath □ other _____

RESPIRATORY: □ no problem
□ chronic cough □ shortness of breath □ wheezing □ home oxygen □ other _____

GASTROINTESTINAL: □ no problem
□ nausea/vomiting □ change in bowel movement □ bloody/black tarry stools □ constipation □ abdominal pain
□ diarrhea □ other _____

GENITOURINARY: □ no problem
□ incontinence of urine □ changes in urinary pattern □ difficulty with erections □ kidney stones □ blood in urine

□ other _____

MUSCULOSKELETAL: □ no problem
□ limited range of motion_____ □ muscle joints/aches □ muscle loss where?_____ □ stiffness in Joints □ other _____

INTEGUMENTARY (SKIN): □ no problem
□ rash □ tumors □ discoloration □ itching □ eczema/psoriasis □ changes in moles □ other _____

NEUROLOGIC : □ No problem
□ Poor appetite □ frequent/severe headaches □ weakness-where?_____ □ difficulty walking □ poor memory
□ difficulty chewing/swallowing □ poor coordination □ dizziness □ recent falls □ other_____

PSYCHIATRIC: □ no problem
□ frequent sadness/depression □ anxiety □ loss of interest □ excessive worry □ low energy level □ suicidal thoughts

□ other_____

ENDOCRINE: □ no problem
□ glucose/sugar changes □ excessive urination □ excessive thirst □ heat/cold intolerance □ other _____

HEMATOLOGIC : □ no problem
□ easy bruising □ Anemia (low blood count) □ trouble controlling bleeding □ other _____

ALLERGIC/ IMMUNOLOGIC : □ no problem
□ difficulty breathing □ swelling pain at groin, axilla, neck □ rash/itch to materials, food, animals □ other_____

Patient signature_____ Provider_____ Date_____

CENTER for SPINE & ORTHOPEDICS

PATIENT CORRESPONDENCE QUESTIONNAIRE

Please list any family members or other persons, if any, whom we may discuss your general medical condition or your diagnosis with (including treatment, payment and health care operations) on your behalf. This contact will also be used in case of an emergency.

Printed Name:_____ Relationship:_____
Phone Number:_____ Phone Number:_____

Printed Name:_____ Relationship:_____
Phone Number:_____ Phone Number:_____

Patient Printed Name:_____Date:_____

Patient/Guardian Signature:_____

In order to provide quality care, we like to have a comprehensive list of your medications. We have the ability to access information provided by your insurance company to populate your medication history directly into your electronic medical record. I authorize The Center for Spine and Orthopedics, P.C. to obtain this information and populate it into my record.

Patient Printed Name:_____Date:_____

Patient/Guardian Signature:_____

I authorize the Center for Spine and Orthopedics P.C. to send me automated messages regarding my medical care (including treatment, payment, and health care operations). This may include phone calls, text messages or emails which may be generated from our electronic medical records system.

Patient Printed Name:_____Date:_____

Patient/Guardian Signature:_____

Center for Spine and ORTHOPEDiCS

Patient Name: _____
First Middle Last

Birth Date: _____ **Age**: _____ **Sex**: _____ **SSN**: _____ **Marital Status**: _____

Home Address: _____
Street Apt. City State Zip
Email Address: _____@_____

Phone: Home (_____)_____ mobile (_____)_____

Employer: _____ Ph: (_____) _____

Address: _____

Preferred Communications: Home phone_____ Mobile phone message_____ mobile phone text_____ email_____

Race:_____ ☐ Declined **Ethnicity:**_____ ☐ Declined **Preferred language**_____ ☐ Declined

REFERRING PHYSICIAN:

Name: _____ph_____

PRIMARY CARE PHYSICIAN:

Name: _____ph_____

TYPE OF INJURY: ☐ Work Comp ☐ Auto Accident ☐ Other Date of Injury: _____

PRIMARY INSURANCE :_____

Claim/ID#: _____

Group#: _____

Co-Pay: _____

Policy Holder (if different from self)

Name: _____

SSN: _____

Birth Date: _____

SECONDARY INSURANCE: _____

Claim/ID#: _____

Group#: _____

Co-Pay: _____

Policy Holder (if different from self)

Name: _____

SSN: _____

Birth Date: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? ☐ Insurance Co ☐ MD Referral ☐ Internet/Website ☐ Family/Friend ☐ ER ☐ Other

EMERGENCY CONTACT INFORMATION:

Name: _____ Relation: _____ ph # _____

Is this person authorized to receive information regarding your medical condition? ☐ Yes ☐ No

DISCLOSURE AGREEMENT AND CONSENT FOR TREATMENT:

I WILL UNDERTAKE NO AUDIO AND/OR VIDEO RECORDINGS WHILE AT THE CENTER FOR SPINE AND ORTHOPEDICS, P.C. I VOLUNTARILY CONSENT TO EXAMINATION AND TREATMENT FOR MYSELF AND/OR DEPENDANTS.
*Note: The providers at CSD may have a financial interest in surgery centers, hospital facilities, imaging centers, and medical-surgical implant distributors
Please Note: Our surgical physicians **do not prescribe pain medications for chronic pain management**. Thank you for your consideration in this matter.

Patient Signature/
Responsible Party: _____ Date: _____

ASSIGNMENTS OF BENEFITS: I understand that I am responsible for payment of services rendered to me. I understand that the office of Center for Spine and Orthopedics, PC does not accept responsibility for collecting of insurance. We may bill insurance as a courtesy, but have no obligation to do so. Any balance left over or co-pay from insurance will be my financial responsibility. A finance charge will be charged at an interest rate of 1.5% per month on any outstanding balance. Should my account be referred to an attorney for collection, I agree to pay attorney fees, costs and collection expenses. I authorize payment of medical benefits to Center for Spine and Orthopedics, PC for services provided to me.

Patient Signature/Responsible Party_____ Date_____

RECORDS RELEASE: I authorize the release of any information, including medical and billing information, by Center for Spine and Orthopedics, PC, to my referring doctor and insurance company.
Patient signature/Responsible Party_____ Date_____

NOTICE OF PRIVACY: A copy of the Notice of Privacy Practices has been made available to me by Center for Spine and Orthopedics, PC.
Patient signature/Responsible party _____Date_____