

**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
_____	_____
_____	_____

<b>FAMILY MEDICAL HISTORY</b>			<b>Relationship to you</b>				<b>Relationship to you</b>
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

**Patient name:** \_\_\_\_\_

**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?**\_\_\_\_\_

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Previous Health care providers you have seen for this problem?

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**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
- Abruptly, remaining the same
- Abruptly, and getting worse
- Gradually, getting better
- Gradually, remaining the same
- 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\_\_\_\_\_

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**How often do you have pain?**

- Constantly
- Occasionally(several times per week)
- Intermittently(several times per day)
- Rarely(a few times per month)

**What makes your pain WORSE (check all that apply)?**

- Sitting
- Lifting
- Standing
- Lying down
- Looking over your shoulder(R or L)
- Other
- Coughing
- Twisting
- Walking
- Exercise
- Sneezing
- Bending Forward
- Bending Backward
- Stress
- Looking up
- Looking down
- Weather Changes
- Bowel movements

**What makes your pain BETTER (check all that apply)?**

- Standing
- Sitting
- Exercise/activity
- Medications- if yes which one(s):\_\_\_\_\_
- Other:\_\_\_\_\_
- Nothing
- Lying down
- Cold
- Rest
- Heat
- 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:**

<b>Treatment</b>	<b>Did it help (yes / no)?</b>		<b>Treatment</b>	<b>Did it help (yes / no)?</b>	
<input type="checkbox"/> Physical therapy	Yes	No	<input type="checkbox"/> Psychiatric Care	Yes	No
<input type="checkbox"/> Chiropractic care or manipulations	Yes	No	<input type="checkbox"/> TENS Unit	Yes	No
<input type="checkbox"/> Psychological Care	Yes	No	<input type="checkbox"/> Accupuncture	Yes	No
<input type="checkbox"/> Pain Program / Pain Clinic	Yes	No	Other:_____		
<input type="checkbox"/> 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 inJoints  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** \_\_\_\_\_

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 :** \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_

**Claim/ID#:** \_\_\_\_\_

**Claim/ID#:** \_\_\_\_\_

**Group#:** \_\_\_\_\_

**Group#:** \_\_\_\_\_

**Co-Pay:** \_\_\_\_\_

**Co-Pay:** \_\_\_\_\_

**Policy Holder (if different from self)**

**Policy Holder (if different from self)**

**Name:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**SSN:** \_\_\_\_\_

**SSN:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_

**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** \_\_\_\_\_