

PATIENT HISTORY

Pro Sports/Pro Spine

Please fill out completely.

DATE: _____

Patient Name: _____ Age: _____ D.O.B. ____/____/____

Occupation: _____ Ht. _____ Wt. _____

Referring M.D. _____ Family M.D. _____

Current medications: _____

Are you allergic to any medications: yes no List: _____

Are you allergic to latex: yes no

Describe the problem(s) you are being seen for today: _____

Have you been previously treated for this problem? yes no Where: _____

Pharmacy name: _____ Location: _____

Are you Disabled? yes no Work related? yes no Military? yes no

Were you seen in the Emergency Room? yes no Lawsuit involved: yes no

Have you had recent Xray studies? yes no Where: _____

PATIENT HISTORY

Anemia _____
 Arthritis _____
 Rheumatoid Arthritis _____
 Asthma/Emphysema _____
 Back Disorders _____
 Bursitis _____
 Bleeding Diseases _____
 Cancer _____
 Where? _____
 Diabetes _____
 Heart Disease _____
 Hepatitis _____
 High Blood Pressure _____
 HIV (AIDS) _____
 Kidney Infection _____
 Kidney Stone _____
 Lung Disease _____
 Lyme Disease _____
 Paralysis _____
 Phlebitis _____
 Pneumonia _____
 Rheumatic Fever _____
 Stroke _____
 Thyroid Disease _____
 TB _____
 Other _____

 Seizures _____
 Mental Illness _____
 Leukemia _____

REVIEW OF SYSTEMS

Prior Problem/risk of Anesthesia _____
 Diseases of Eyes, Nose, Throat _____
 Sinusitis _____
 Loss of Hearing _____
 Indigestion, Heartburn _____
 Hiatal Hernia _____
 Peptic Ulcer/ Stomach pain _____
 Gallbladder Disease _____
 Bowel Disease _____
 (i.e. Colitis, Diverticulitis) _____
 Intestinal Bleeding _____
 Frequent Urination _____
 Burning on Urination _____
 Difficulty Starting Urination _____
 Shortness of Breath _____
 Chills or Fever _____
 Heart/Chest Pain/ Angina _____
 Abnormal Heart Beat _____
 Muscle Weakness _____
 Joint Pain/Stiffness _____
 Joint Swelling _____
 Calf Cramps Walking _____
 Recent Weight Loss _____
 Leg/Skin Ulcers _____
 Mental Illness/Addiction _____
 Gout _____
 Psoriasis _____

SOCIAL HISTORY

Married Single Divorced
 Partnered Widowed
 Number of Children Living? _____
 Presently living alone? yes no
 Do you smoke? yes no
 _____ never
 If no, when did you quit? _____
 Alcohol? never occasional
 _____ moderate to heavy family history
 Drug overuse? never present
 _____ past problem

PREVIOUS SURGERIES

Tonsils _____
 Gallbladder _____
 Appendix _____
 Prostate _____
 Hysterectomy/ovaries _____
 Cancer _____
 Back/Disc _____
 Fracture _____
 Other _____
 List: _____

Major cause of death in family ...

Cancer _____
 Diabetes _____
 Heart Disease _____
 Hypertension _____
 Accident _____

Reviewed with patient by: _____ M.D.