Past Medical History

A. Please list *all* medical issues ***past*** or ***present,*** related or unrelated to this visit. Please include treatment and the medical doctor currently caring for each issue: *(use back of page if necessary)*

	Medical History	Treatment	Treating Physician
1			
2			
3			
4			
5			

B. Please list all past surgical procedures: *(use back of page if necessary)*

	Surgery	Year	Surgeon	Did symptoms resolve?
1				☐ Yes ☐ No
2				☐ Yes ☐ No
3				☐ Yes ☐ No
4				☐ Yes ☐ No
5				☐ Yes ☐ No

C. Please list any medications you are taking: *(use back of page if necessary)*

	Medication	Dose/Times per day	Taken for	Prescribing MD
1				
2				
3				
4				
5				

D. Please list all injuries you can recall: *(use back of page if necessary)*

	Injury	Date	Comments
1			
2			

E. Please list all medication and food allergies: *(use back of page if necessary)*

	Allergy	Type of reaction
1		
2		
3		

Do you have, or have you ever had, a physician prescribed back brace? ☐ Yes ☐ No

(843) 379-7746

Social History

A. Do you currently smoke? ☐ No ☐ Yes How many packs/day?_____ How many years?_____

If you quit smoking, approximately how long ago did you quit?_____

B. Do you drink alcohol? ☐ No ☐ Yes How many drinks/week?_____

C. What is your current marital status?_____

List the people who live in your household including their relation to you and age:_____

_____

D. Highest level of education completed:

☐ High School ☐ College ☐ Graduate School ☐ Other _____

Current or last occupation:_____

What is your current work status?

☐ Full-time without restriction
☐ Part-time or light duty
☐ Unemployed
☐ Retired
☐ Unable to work

If unable to work, how long have you been unable to work and why:_____

_____

_____

_____

E. Please check all that apply:

1. Are your symptoms related to: ☐ **On the job injury** ☐ **Motor vehicle accident**
2. Have you applied for or received: ☐ **Workers Compensation** ☐ **Social Security Disability**
3. Have you required an attorney to assist you with your current medical situation? ☐ Yes ☐ No

Family History

A. Do any of the following illnesses run in your family? *(check all that apply)*

☐ Cancer ☐ Diabetes ☐ Heart Disease
☐ Scoliosis ☐ Ankylosing Spondylitis ☐ Rheumatoid Arthritis
☐ Other _____

B.	Living	Deceased	Current age or age at death	Serious illnesses and/or Cause of death (if applicable)
Mother	☐	☐		
Father	☐	☐		

C. Has anyone in your family had difficulty with anesthesia? ☐ No ☐ Yes

If yes, please explain:_____

Review of Systems

A. Please check (√) the line beside each condition or diagnosis as it applies to you:

Now	Past	Never	
☐	☐	☐	Recent weight loss _____
☐	☐	☐	Persistent fevers or chills _____
☐	☐	☐	Diagnosis of cancer _____
☐	☐	☐	Visual disturbances such as spots or double vision _____
☐	☐	☐	Hoarseness _____
☐	☐	☐	Difficulty swallowing _____
☐	☐	☐	Toothache or abscess _____
☐	☐	☐	Peripheral vascular disease or hardening of the arteries _____
☐	☐	☐	Chest pain or angina _____
☐	☐	☐	Heart attack or heart disease _____
☐	☐	☐	Congestive heart failure (CHF) _____
☐	☐	☐	Abnormal heart beat _____
☐	☐	☐	Shortness of breath _____
☐	☐	☐	Asthma or bronchitis _____
☐	☐	☐	COPD or lung disease _____
☐	☐	☐	Use of supplemental oxygen day or night _____
☐	☐	☐	Tuberculosis (TB) or positive PPD _____
☐	☐	☐	Stomach discomfort with medicine _____
☐	☐	☐	Ulcer _____
☐	☐	☐	Hepatitis _____
☐	☐	☐	Loss of control of urine or stool _____
☐	☐	☐	Difficulty starting urination _____
☐	☐	☐	Burning with urination _____
☐	☐	☐	Rashes _____
☐	☐	☐	Areas of non healing sores _____
☐	☐	☐	Frequent headaches or migraines _____
☐	☐	☐	Peripheral neuropathy _____
☐	☐	☐	Stroke _____
☐	☐	☐	Seizures _____
☐	☐	☐	Depression or other psychiatric illness _____
☐	☐	☐	Diabetes or blood sugar control issues _____
☐	☐	☐	Bleeding problems or blood clots _____
☐	☐	☐	Anemia _____
☐	☐	☐	Latex allergy _____
☐	☐	☐	Shellfish or iodine allergy _____
☐	☐	☐	Contrast allergy _____

B. Do you have any other joint, bone or muscle problems for which you see a health care provider?

☐ No ☐ Yes If yes, please explain _____

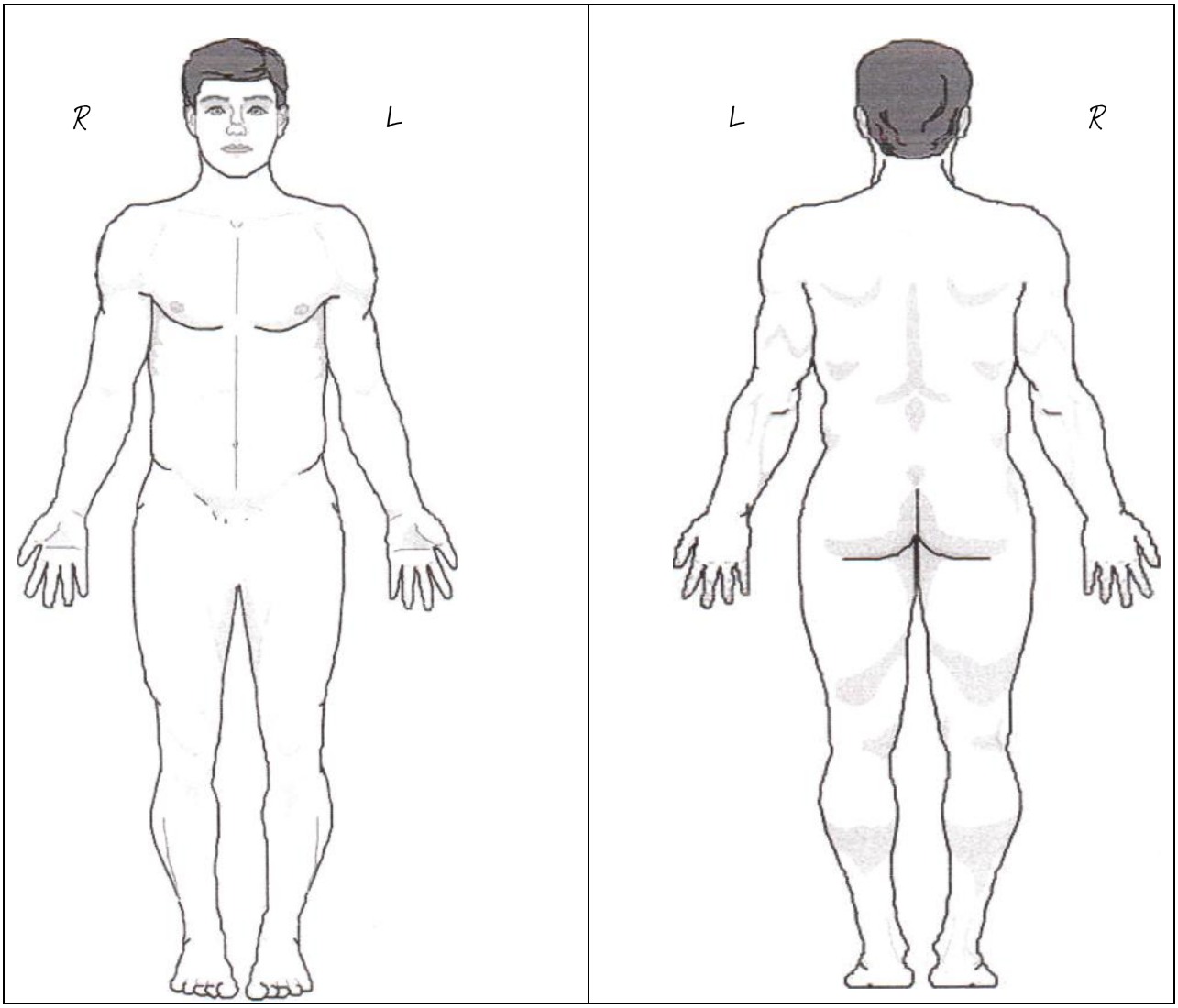
_____

PMSFH and ROS reviewed with patient during clinical encounter date

Visual Analog Pain Scale (VAS)

Mark the areas on your body where you feel the described sensations using the appropriate symbols from the table below:

Numbness	Pins & Needles	Burning	Stabbing	Aching
= = = = = =	o o o o o o o	x x x x x	/ / / / /	Δ Δ Δ



Indicate your pain level by placing a line inside the charts below with a “0” for no pain and a “10” for the worst imaginable pain:

Pain at its worst:	0	5	10

Pain at its best:	0	5	10

Patient Name: _____ **Date:** _____