PLEASE COMPLETE YOUR NAME & DOB ON EACH PAGE:

Name: _____
DOB: _____
Appt Date: _____

Southern Oregon SPINE CARE

PATIENT CONFIDENTIAL HEALTH HISTORY

Primary Care Physician:_____ Referring Physician:_____ Pain Specialist:_____

Reason for today's visit: _____

Social Status: (Circle) Married Single Divorced Widowed

Result of a (n): Accident _____ Other_____

Date of Onset _____ Occupation_____

Have you had any of the following Diagnositc Tests? If so, please indicate when and where:

CT Scan_____ MRI_____ EMG_____ XRAY_____ Bone Density_____

Past/Present Illnesses: Please **circle** illnesses you have had or have now:

Diabetes	Anemia	Stomach Ulcers	Epilepsy
Heart Disease	Eye Disease	Head Injury	Migraine
High Blood Pressure	Arthritis	Liver Disease/Hepatitis	Bowel Disease
Immune-deficiencies	Cancer/type_____	Pneumonia	Alcoholism
Blood Clots	Radiation	Depression	Tuberculosis
Cortisone Therapy	Rheumatic Fever	Drug Abuse	Asthma
COPD	Kidney Disease	Gallbladder Disease	Stroke
Bleeding Problems	Thyroid Disease	Sleep Apnea	

Other_____

Past Surgeries/Hospitalizations	**Year**	**Complications**

Presently taking any **Anticoagulants** (blood thinners)?	Yes No List: _____
Presently taking **Fish oil?**	Yes No
Have you ever had general anesthesia?	Yes No
Any problems with anesthesia?	Yes No List: _____
Do you have an allergy to **Latex?**	Yes No
Do you have food allergies?	Yes No List: _____
Are you pregnant now? (if applicable)	Yes No
First day of last menstrual period (if applicable)	Date: _____
Allergies/Sensitivities to medications?	Yes No List: _____

_____

Please turn over…->

Name: _____
DOB: _____

Medication List

Name of the Medication	Dose	Frequency	Doctor

List any herbal supplements or vitamins you are taking:

_____

_____

Family History

Please list any history of family illnesses / diseases:

Mother: _____ Father: _____ Siblings: _____

Grandmother: _____ Grandfather: _____ Children: _____

Social History (circle all that apply)

Exercise: Daily Weekly Monthly Rarely Never

Type_____ Duration_____

Smoking: Current every day smoker Current some day smoker Former Smoker
Never Smoker Chewing Tobacco

*If yes, for how long _____

Drink Alcohol: No Yes

Drug use: Never Quit Yes *If yes, what type(s) _____

Review of Systems

Please **circle** symptoms that you are **currently experiencing TODAY.**

Fever / Chills
Fatigue
Vision changes
Sore throat
Nasal Stuffiness / Drainage
Hearing changes / Ear pain
Anxiety
Chest pain / pressure
Palpitations
Shortness of breath
Difficulty breathing
Cough
Wheezing
Depression
Nausea / Vomiting
Diarrhea / Constipation
Urinary pain / urgency / incontinence
Joint pain / Muscle weakness
Changes to skin, hair, or nails
Numbness: Arms / Hands / Legs/ Feet
Dizziness