Staff section

Date: ____________

Acct #: ___________

New Patient History Sheet

Patient Name: ____________________________ Date of Birth: ___________

Age: _______ Family physician: ___________________________________

May we send a copy of the clinic notes to your primary care doctor (family physician)?: Yes No

Email address: __________________________ Are you pregnant? Yes / No

Who referred you to MOI Spine? ____

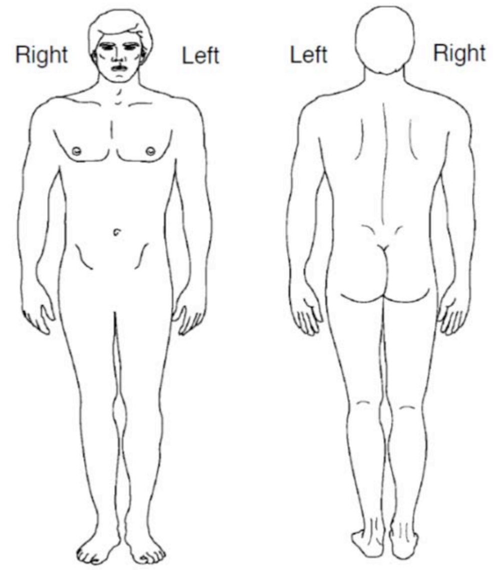
Reason for today's visit: ____

When and How did it start? ____

If it was an accident, how did the accident occur? ____________________________

Is this a work-related injury? Y N If yes, did you file a Worker's Comp Claim? Y N

Did you notify your employer? Y N Are you still working? Y N If no, your last day of work: ___________



PAIN DESCRIPTIONS:

Please mark the figure with the location of your symptoms.

Pain = P
Numbness = N
Tingling = T

Qualities of your pain: Aching / Dull / Sharp / Burning / Numb / Tingling

Frequency of your pain: Constant / Comes & Goes

When is your pain at the worst…? Mornings / During day / Evenings

Associated symptoms (in the past 3 months):

Loss of bowel/bladder control? Depression? Difficulty sleeping?

Tripping/falling? Severe muscle weakness? Numbness between thighs/groin?

How does the pain affect your life? (What can you no longer do?) ___________________________________

____

Pain BETTER with: Sitting - Standing - Lying on back - Leaning forward - Arching back - Hot packs

Other: ____

Pain WORSE with: Sitting - Standing - Leaning forward - Arching back - Walking - Cough/sneeze

Other: ____

Pain scores for _____________ (name body part) /10 today; /10 at worst; /10 at best; /10 on average

Pain scores for _____________ (name body part) /10 today; /10 at worst; /10 at best; /10 on average

**** PLEASE COMPLETE OTHER SIDE ****

Have you had any of the following for this condition? MRI CT scan X-ray EMG/NCS

Have you had any of the following treatments for <u>THIS</u> pain? NSAIDS Oral steroids Narcotics Surgery Injections Physical Therapy Chiropractor If yes, describe: ______________________________

PAST MEDICAL HISTORY: CIRCLE if you have (or have had) these conditions or any others

Stroke ________________ Osteoporosis ________________ Hepatitis ________________

Heart trouble ________________ Seizures ________________ Stomach ulcers / Reflux

High blood pressure __________ Depression ________________ Easy bleeding ______________

Diabetes ________________ Anxiety ________________ Blood clots ________________

Cancer ________________ Kidney problems ____________

Other conditions ____

PAST SURGICAL HISTORY: Please list **all** surgeries and dates that you have had

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

SOCIAL HISTORY:

Occupation: ________________________ Duties at work: ______________________________

Marital Status: S M W D Do you live alone or with family?:______________________________

Do you smoke? Y N Amount: ____________ Did you quit smoking? Y N When________________

Do you use alcohol? Y N Amount: ______________ How often: ______________________

Do you exercise? Y N How Often: ____

History of narcotic or prescription medication abuse? Y N What? ______________________

Activities or sports you're involved in: ____

FAMILY HISTORY:

Major medical problems or cause of death

Mother:	Alive / Deceased	______________________________
Father:	Alive / Deceased	______________________________
Sibling:	Alive / Deceased	______________________________
Sibling:	Alive / Deceased	______________________________

<u>Do you have Allergies to Food or Drugs?</u> Y N
Please describe and include reactions:

<u>MEDICATIONS</u>: **See attached list** **Pharmacy: ____________________ (city) _______________**

Please list **<u>ALL</u>** prescription, over-the-counter, and herbal medications you may be taking. Also, please list the dosage, frequency, and reason for each medication.

List ANY <u>blood thinners</u> use take? ____

Name of Medication	***Dosage***	***Frequency***	***Reason***

<u>REVIEW OF SYSTEMS</u>:

CIRCLE if you have been troubled with any of the following symptoms **<u>WITHIN THE LAST 4-6 WEEKS</u>?**

Unexplained weight loss / Fever / Chills

Blurred vision

Chest pain / Fainting

Cough / Shortness of breath

Loss of urine control / Blood in urine

Joint pains / Joint swelling

Rashes / Poor healing

Heartburn / Constipation / Diarrhea / Blood stools

Seizures / Unsteady gait

Anxiety / Depression

Easy bleeding / New bruising / Leg fatigue

Excessive thirst / Heat intolerance

Reactions to foods

Headaches / Difficulty swallowing

MOI Spine would like to <u>thank you</u> very much for taking the time to provide the necessary information regarding your symptoms and previous medical care.

Patient's Signature: ______________________________________ Date: _______________

Spine Tech Initials: ____ Doctor Initials _____

<u>For Staff notes:</u>

PT:

Injections:

Antidepressants:

Blood thinners:

Renal dz:

BP:
HR:
Temp:
HT:
WT: