SOUTH TEXAS SPINAL CLINIC
PATIENT HISTORY FORM

ACCT #:_____ DATE:_____

Patient's Legal Name: _____
Last Name *First Name* *M.I.*

Age:_____ Date of Birth:_____ Education Level: (Highest level attained) _____

Primary Care / Family Physician: _____

Referring Physician: _____

□ Initial Office Visit □ Second Opinion □ IME
□ Workers Compensation □ Consultation □ Other _____

REASON FOR VISIT: My area of pain or complaint(s) is/are:

What part of your body is experiencing the GREATEST pain? _____

Location of pain: _____ Rate the pain from 0=none to 10= unbearable: _____
Location of pain: _____ Rate the pain from 0=none to 10=unbearable: _____
Location of pain: _____ Rate the pain from 0=none to 10=unbearable: _____

□ **sudden** since _____
□ **gradually** since _____
□ **following** an injury on _____

□ no prior low back pain
□ a history of low back pain for _____ years

□ no prior neck pain
□ a history of neck back pain for _____ years

_____

_____

_____

MID TO LOW BACK:
Pain quality: □ aching □ sharp □ burning □ cramping □ stabbing
Pain location: □ middle of low back □ to L R □ across buttock / back

NECK:
Pain quality: □ aching □ sharp □ burning □ cramping □ stabbing
Pain location: □ middle of low back □ to L R □ across buttock / back

Dominant hand □ Left □ Right

PATIENT HISTORY FORM

ACCT #: _____ DATE: _____

PAST MEDICAL HISTORY:

ALLERGIES:
List all medications you are allergic to and the reaction you have:_____
_____
_____
_____

MEDICATIONS:
List all medication you are now taking and what they are for: _____
_____
_____

PAST HOSPITALIZATION / SURGICAL HISTORY:
Check any previous SPINAL surgeries and when they happened:
□ NONE □ Lumbar _____ □ Cervical _____ □ Thoracic _____

Check all OTHER surgeries: □ NONE □ appendectomy □ cardiac surgery □ tonsil / adenoidectomy
□ wisdom teeth removal □ gall bladder surgery □ other orthopedic surgery □ thyroid surgery
□ breast surgery □ hernia repair □ Cesarean section □ Other _____

OTHER INJURIES: _____
_____

REVIEW OF SYSTEMS: CHECK ANY ITEM THAT APPLIES TO YOU:

Musculoskeletal / Joints:	□ Muscular disease	□ Arthritis			
Neurological:	□ Headaches	□ Migraines	□ Seizures / Epilepsy	□ Strokes	
Metabolic:	□ Diabetes	□ Thyroid problems			
Bleeding Disorders:	□ Anemia	□ Blood Clots	□ Bleeding Problems		
Urinary:	□ Blood in Urine	□ Frequent Urination	□ Trouble Starting Urination		
	□ Trouble Stopping Urination	□ Pain with Urination	□ Prostate Disease		
	□ Kidney Disease				
Respiratory:	□ Asthma	□ Bronchitis	□ COPD	□ Emphysema	
	□ Pneumonia	□ Tuberculosis			
Cardiovascular:	□ Chest Pain	□ Mitral Valve Prolapse	□ Irregular Heartbeats		
	□ High Blood Pressure	□ Shortness of Breath			
Reproductive:	□ Infections	□ Herpes	□ Venereal Disease		
Gastrointestinal:	□ Stomach Ulcers	□ Gallbladder Problems	□ Pancreatitis		
	□ Colitis	□ Blood in Stool	□ Hiatal Hernia		
	□ Liver Disease	□ Constipation	□ Loss of Bowel Control		
	□ Hepatitis	□ Jaundice			
Cancer:	□ Lung	□ Breast / Colon / Intestinal	□ Stomach	□ Prostate	□ Skin
	□ Kidney	□ Bone	□ Other Malignancy _____		
Immunological Diseases:	□ HIV Infection / AIDS				
WOMEN ONLY:	□ Endometriosis				
Are you on the Pill?	□ NO □ YES	Are you pregnant now?	□ NO	□ YES due date: _____	

How long ago was your last complete physical? _____ yrs _____months
Where there any abnormal findings? □ NO □ Yes, describe: _____

PATIENT HISTORY FORM

ACCT #: _____ DATE: _____

Other medical history:

Do you smoke NOW?	□ No	□ Yes: Packs per day: _____ for _____ years
Did you smoke in the Past?	□ No	□ Yes: Packs per day: _____ for _____ years
Do you drink alcoholic beverages?	□ No	□ Yes: Drinks per week: _____ for _____ years
Do you have a history of drug abuse?	□ No	□ Yes: Please describe: _____

SOCIAL HISTORY:

Patients Marital Status: □ Married □ Single □ Widowed □ Divorced □ Separated

Number of children: _____

Hobbies: _____ Spouse Occupation: _____

FAMILY HISTORY:

Please check any of the problems immediate family have had and indicate the family member:

□ Diabetes	□ High Blood Pressure	□ Neck Pain
□ Heart Disease	□ Low Blood Pressure	□ OTHER _____
□ Vascular Disease	□ Cancer	

OCCUPATIONAL HISTORY:

Occupation: _____

Employer: _____ When did this employer hire you? _____

Presently Working? □ Yes □ No How long off work? _____

ADDITIONAL PATIENT INFORMATION: (Provide additional explanation of any response on this form in the space below and on back of sheet)

I hereby certify by my signature that the medical information given on this form is correct and complete to the best of my knowledge.

_____	_____	_____
Patient Signature	Date	Verified by Physician/Nurse

[OVER]

INSTRUCTIONS: Use the appropriate symbol(s) below (as many as needed) and rate each.

PAIN SEVERITY SCALE: **MILD – 1 2 3 4 5 6 7 8 9 10 - - INTOLERABLE**

□ **NUMBNESS (SYMBOL: *)**
How would you rate this pain: _____

□ **PINS & NEEDLES (SYMBOL: O)**
How would you rate this pain: _____

□ **BURNING (SYMBOL: X)**
How would you rate this pain: _____

□ **STABBING (SYMBOL: /)**
How would you rate this pain: _____

□ **DEEP ACHE OR PAIN (SYMBOL: A)**
How would you rate this pain: _____

How would you rate this pain: _____