Spine Group Arizona

HONORHEALTH Scottsdale Osborn Medical Center

OFFICE USE ONLY - PATIENT LABEL HERE

YOUR MEDICAL HISTORY page 1

1 Patient information

Chart # _____

Last Name _____ First Name _____

Phone _____ E-mail (optional) _____

Today's Date (M/D/Y) ___ / ___ / ___ Date of Birth (M/D/Y) ___ / ___ / ___ Age ___

Sex: ☐ Male ☐ Female Height _____ Weight _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Referring Doctor _____

2 Your symptoms

What problem/issue brings you in today _____

When did it start & what were you doing when it started? ☐ Fall ☐ Auto accident ☐ At work

What is the timing of your pain? Select all that apply:

☐ Constant ☐ Getting worse ☐ Comes & goes ☐ Getting better ☐ Not changing

Do you have ANY pain that radiates into the arm or leg? ☐ Yes ☐ No

(If yes, describe) _____

Describe your pain in words (select all that apply) ☐ Dull ☐ Stabbing ☐ Pulling

☐ Achy ☐ Numbness ☐ Cramping ☐ Burning ☐ Tingling ☐ Tightness

What makes the pain worse? (sitting, standing, lifting) _____

What things makes the pain better? (rest, ice, heat, pills) _____

Do you have any numbness or tingling in an arm or leg? ☐ Yes ☐ No

(If yes, describe) _____

Do you have any weakness in an arm or leg? (i.e. footdrop) ☐ Yes ☐ No

(If yes, describe) _____

Do you have any trouble walking due to this pain? ☐ Yes ☐ No

Do you have any bowell/bladder issues or groin numbness? ☐ Yes ☐ No

How long can you: _____ Sit _____ Stand _____ Walk

3 Current work status

Is there a law suit pending on problem? ☐ Yes ☐ No

Which of the following describes you currently?

☐ Working; if yes: ☐ Full duties ☐ Limited

☐ Not working because of back or neck problem

☐ Not working because of another health problem

☐ Homemaker, retired or unemployed

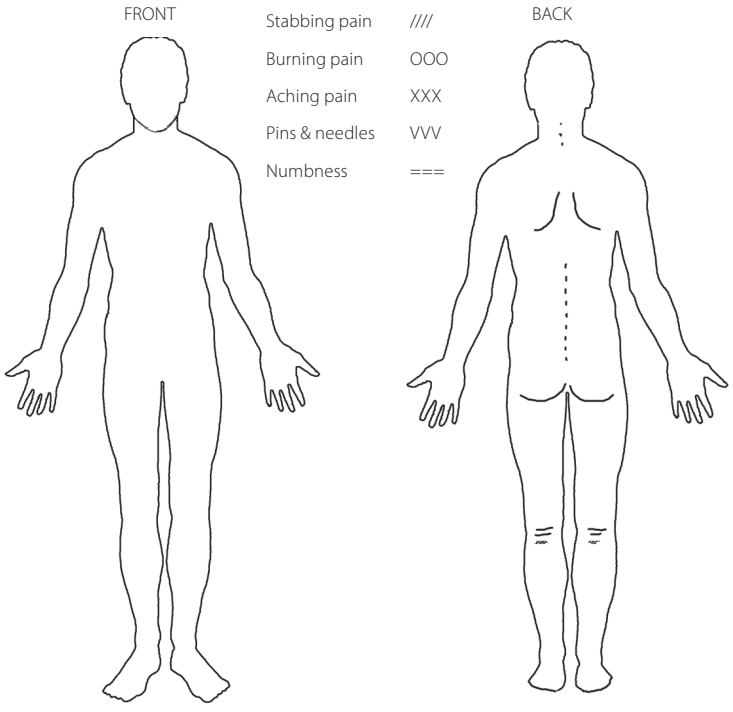
How long have you been at that job? _____

Does your job require lifting, standing, sitting? ☐ Yes ☐ No

Employer at time of injury _____

4 Your pain

Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.



Circle your pain level on a scale of 1 to 10, with 10 being unbearable pain.

0 1 2 3 4 5 6 7 8 9 10

no pain extreme pain

- FOR OFFICE USE ONLY -

PHYSICIAN REVIEW: _____ Date:

Spine Group Arizona

HONORHEALTH Scottsdale Osborn Medical Center

3621 North Wells Fargo Ave.
Scottsdale, AZ 85251
Phone: 480-882-5566
SpineGroupArizona.com

YOUR MEDICAL HISTORY page 2

5 Previous treatments & tests

Name of the doctor that treated you FIRST for this problem and the city. _____

What tests have you had? ☐ CT scan ☐ MRI ☐ X-ray ☐ EMG
☐ Other (list) _____

What treatments have you had? ☐ Physical Therapy ☐ Medications ☐ Injections
☐ Chiropractics ☐ Psychological ☐ Acupuncture ☐ Other _____

Did physical therapy help? ☐ Yes ☐ No ☐ N/A

Do you do any special exercises for your back or neck? ☐ Yes ☐ No
(If yes, describe) _____

Did you have any injections for your problem? ☐ Yes ☐ No
(If yes, describe) _____
Did these injections help? ☐ Yes ☐ No
(If yes, describe) _____

Did you have previous back or neck surgery? ☐ Yes ☐ No
(If yes, describe) _____
List any other PREVIOUS SURGERIES you had, and dates: _____

Do you have any adverse reactions to anesthesia? ☐ Yes ☐ No
(If yes, describe) _____

Have you ever had a blood transfusion? ☐ Yes ☐ No
(If yes, describe) _____

List any medications you are taking: _____

What other medications have you tried? _____

List any ALLERGIES you have to medications, foods, etc. _____

What do you hope we can accomplish today? _____

What other concerns do you have? _____

- FOR OFFICE USE ONLY -

Height: _____ Pulse rate: _____
Weight: _____ Respirations: _____
Temperature: _____ Pain Level: _____
Blood Pressure: _____ Notes: _____

PHYSICIAN REVIEW: _____ Date:

6 Your health

Do you smoke? ☐ Yes ☐ No (If yes, how many packs a day?) _____
Illicit drug use? ☐ Yes ☐ No (If yes, what drugs?) _____
History of drug abuse? ☐ Yes ☐ No (If yes, please describe) _____
Do you drink alcohol? ☐ Yes ☐ No (If yes, how many drinks per week?) _____
Do you use an assistive device (cane / walker / wheelchair) ? ☐ Yes ☐ No
How many falls have you had in the last 12 months ?
☐ None ☐ One, WITH injury ☐ One, WITHOUT injury
☐ Two or more, WITH injury ☐ Two or more, WITHOUT injury

Do you have any of the following medical problems:

AIDS/HIV	☐ Yes ☐ No	Thyroid problems	☐ Yes ☐ No
Arthritis or joint pain	☐ Yes ☐ No	Anxiety/Depression	☐ Yes ☐ No
Bleeding disorders	☐ Yes ☐ No	Recently, have you had...	
Cancer	☐ Yes ☐ No	Fever or chills	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Weight loss	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Chest pain	☐ Yes ☐ No
Heart problems	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	Worse pain at night	☐ Yes ☐ No
High blood pressure	☐ Yes ☐ No	Night sweats	☐ Yes ☐ No
Migraines/headaches	☐ Yes ☐ No	Vision changes	☐ Yes ☐ No
Muscle diseases	☐ Yes ☐ No	Black stools	☐ Yes ☐ No
Swollen ankles	☐ Yes ☐ No	Bloody stools	☐ Yes ☐ No
Nerve problems	☐ Yes ☐ No	Rash	☐ Yes ☐ No
Psychiatric problems	☐ Yes ☐ No	Dizziness	☐ Yes ☐ No
Stomach problems	☐ Yes ☐ No	Suicidal thoughts	☐ Yes ☐ No

Do you have any OTHER medical problems: _____

7 Your family history

Please cirlce: Your mother is LIVING or DECEASED
Please cirlce: Your father is LIVING or DECEASED

Do any family members have a history of:

Cancer	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Heart problems	☐ Yes ☐ No	Back/neck problems	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Migraines/headaches	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Muscle diseases	☐ Yes ☐ No
High blood pressure	☐ Yes ☐ No	Nerve problems	☐ Yes ☐ No
Arthritis or joint pain	☐ Yes ☐ No	Psychiatric problems	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Stomach problems	☐ Yes ☐ No
AIDS/HIV	☐ Yes ☐ No	Thyroid problems	☐ Yes ☐ No
Bleeding disorders	☐ Yes ☐ No		

Other problems? _____