



Name: \_\_\_\_\_ Date: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

When did problem begin: \_\_\_\_\_ Which side: Right Left

How did the pain begin: \_\_\_\_\_ Does it wake you at night: Yes No

What makes the pain worse: \_\_\_\_\_

What makes the pain better: \_\_\_\_\_

Have you had any (circle): X-rays MRI CT scan BoneScan EMG Mylelogram Other: \_\_\_\_\_

When: \_\_\_\_\_ Where: \_\_\_\_\_ Ordered by: \_\_\_\_\_

Have you had Physical Therapy: Yes No Are you still working: Yes No Light Duty

Have you been hospitalized for this problem: Yes No By whom: \_\_\_\_\_

**Medical History:** (continue on back if needed)

Medical Problems: \_\_\_\_\_

**IMPORTANT**

Please list all medications, vitamins, OTC pain relievers, or any other substance taken orally on a regular basis.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Drug, Tape or Dye Allergies:** \_\_\_\_\_

Previous Surgeries: \_\_\_\_\_

Have you ever had a blood transfusion: Yes No

**Family/Social History**

Does anyone in your family have a history of: (circle)

Heart Disease Diabetes Arthritis Stroke

Kidney trouble Muscular disease Mental Illness Other \_\_\_\_\_

Substance Abuse Cancer (please specify): \_\_\_\_\_

Parent's age and health (if deceased: age at death and cause): \_\_\_\_\_

Do you smoke? Yes No How much? \_\_\_\_\_ Have you ever smoked? Current \_\_\_ Former \_\_\_ Never \_\_\_

Do you drink? Yes No How much? \_\_\_\_\_

**Females:** Is there any possibility you are pregnant? Yes No

Are you experiencing any of the following? (circle)

Fever Hearing loss Depression Dysuria

Weight loss Vision loss Insomnia Dark urine

Night sweats Heartburn Adnormal bleeding Asthma

Chest pain Loss of appetite Cough

Irregular heart beat Dizziness Shortness of breath

Rashes Seizures Wheezing

Other \_\_\_\_\_

Reviewed: \_\_\_\_\_