The Spine Center at Tallahassee Orthopedic Clinic
Medical History

Date: ______________________ Chart# ______________________

Patient Name (Please Print) ______________________ Male ____ Female ____ Ht.________

Referring Physician______________________ Age ______________ Wt.________

Primary Care Physician______________________ R ___ L ___ Handed BP _____ Pulse _____

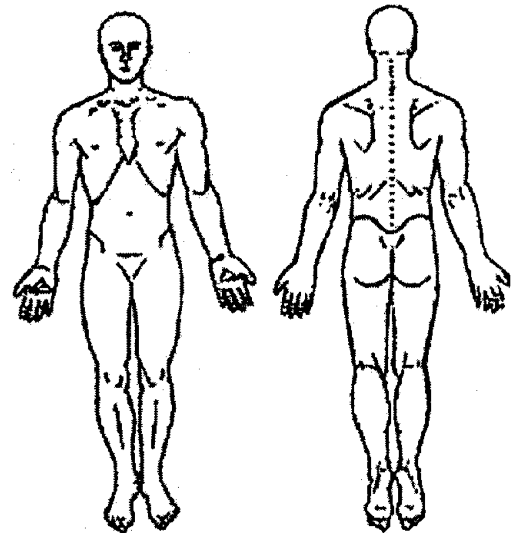
History of Present Illness

Why are you seeing the doctor today? ______________________

When did your symptoms start? ______________ Injury? Y___ N ___ Work? Y___ N ___ Auto? Y___ N ____

Gradual ____ Sudden ____ Onset of symptoms

Where is your pain? Fill in the drawing



Rate your pain on the scale : 0 1 2 3 4 5 6 7 8 9 10 *(Circle)*

What is the quality of the pain? Sharp ____ Dull____ Stabbing _____

Throbbing ___ Aching ___ Burning ___ Other ______________

The pain is: Constant _____ Comes and goes _____

Does your pain wake you? Y____ N_____

Do you have: Swelling ___ Bruising ___ Numbness ___ Tingling ___

Weakness___ Loss of control of bowel or bladder _____

Is your problem: Getting better ___ Worse___ Unchanged___

What makes your symptoms worse? Standing ___ Walking ___

Lifting ___ Exercise ____ Twisting ___ Lying in bed ___ Bending ___

Sitting ___ Squatting ___ Kneeling ___ Coughing ___ Sneezing ___

What makes your symptoms better? Sitting ____ Heat____ Rest ____

Ice ___ Elevation ____ Other ______________________

What medications have you been prescribed for this problem? ______________________

Have you tried: Injections ____ Brace ____ Physical Therapy ____ Chiropractor ____

Tests you have had: X-Rays ____ MRI ____ CT ____ Bone Scan ____ Nerve Test (EMG/NCV) ____

Are you working normal duties? Y____ N____ Have you lost time at work? Y ____ N ____

Medications *(list your medications)*

Name	*Dose*	*Frequency*

Are you now or have you been on any blood thinners?_________

Allergies (to medications, food, airborne particles, iodine, latex, band-aids, etc.)

______________________________ ______________________________

______________________________ ______________________________

Surgical History (list any surgeries you have had & date)

______________________________ __________

______________________________ __________

______________________________ __________

______________________________ __________

______________________________ __________

______________________________ __________

Have you ever had an adverse reaction to anesthesia? Y____ N____

Social History

Married ____ Single ____ Divorced ____ Widowed____

Occupation ______________________________

Employer______________________________

Smoke? Y____ N____ Chew? Y____ N____

How much______________________________

Alcohol: Never Rarely Weekly Daily

Highest Level of Education: ____________________

Family History (Circle any medical problems in your **family — please list disease, family member, age or age at death**)

Cancer	Ulcers	Heart Disease	Scoliosis	Osteoporosis	Muscle Disorders
Arthritis	Blood Disease	Bleeding Disorder	Diabetes	Respiratory	Nerve Disorders

____________________ ____________________ __________ __________

____________________ ____________________ __________ __________

Past Medical History (Circle any medical problems which **you** have)

Heart Disease	High Blood Pressure	Blood Clots	Asthma	Emphysema	Stomach Ulcers
Heart Attack	Kidney Disease	Liver Disease	Thyroid Disease	Osteoporosis	High Cholesterol
Sickle Cell	Diabetes	Arthritis	Seizures	Stroke	Drug Abuse
Depression	Mental Health Disease	Cancer	HIV/AIDS	Anemia	Bleeding Disorder

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Review of Systems:

Have you had prior problems with the same orthopedic condition in the past? Y____ N____

If yes, explain ____

Do you have? (Circle any symptoms which **you** have)

Joint pain	Joint swelling	Fever	Weight Loss	Headaches	Hoarseness
Double vision	Hearing loss	Chest Pain	Palpitations	Sore Throat	Chronic cough
Poor appetite	Heartburn	Nausea	Blurry vision	Alcohol abuse	Vomiting
Painful urination	Blood in stool	Blood in urine	Difficulty breathing		Convulsions
Excessive thirst	Dry Skin	Skin lesions	Skin rash	Bleed easily	Depression
Dizziness	Drug addiction	Difficulty swallowing		Stomach pain with anti-inflam.	

For Office Use Only: Date ____________________ Initials ____________________

Date ____________________ Initials____________________