ORTHOPAEDIC SPECIALIST OF NORTH CAROLINA
PERSONAL MEDICAL HISTORY

Name: _____ Today's Date: _____

Occupation: _____ Birthdate: _____ Age: _____

Why are you seeing the doctor today?

Who sent you to us?

Current problem is the result of (Circle all that apply)
Injury Fall Car Accident Work Accident Other: _____ Date of Injury: _____

Your most strenuous activity is _____

What does you pain keep you from doing?
Household activities: _____

Social activities: _____

Recreational activities: _____

Pain location (Circle all that apply)
Neck, right shoulder, left shoulder, right arm, left arm, upper back, mid back, low back, right buttock, left buttock, right leg, left leg, other _____

Pain Character (Circle all that apply)
Achiness, soreness, stabbing, sharp, throbbing, pins and needles, other _____

What makes your pain worse? (Circle all that apply)

Sneezing	Bending	Lifting
Coughing	Sitting	Standing
Walking	Straining to have a bowel movement	

Other; please list: _____

What makes your pain better? (Circle all that apply)

Bedrest	Cold	Heat
Change in position	Sitting	Medication
Exercise or Activity	Nothing	

Other; please list: _____

Describe treatment you have already tried/had. Physical Therapy? Injections? Chiropractic?

Previous Diagnostic Testing (with dates and locations)
Study Location Date

MRI: _____

MRI: _____

Myelogram: _____

Discogram: _____

Other: _____

Previous Spine Surgeries (please list all with dates)

Past Medication (please list all medication you have taken in the past on a regular basis)

Current Medication (please list all medication you are taking now with doses, it would be good to bring your medication with you to the first visit)

Have you been diagnosed with any other medical conditions that are not spine related? (Please list)

Do you smoke?_____ If yes, number of packs a day_____ For how many years _____
Previously smoked? _____ Packs/day for _____ years. Quit at age _____
Other tobacco products? _____
Drink alcohol? _____ What and how often? _____
Do you have a history of other substance abuse? If so, what? _____
Are you on a special diet? If so, what? _____
Do you exercise? (Circle) Daily Weekly Monthly Rarely Never What type of exercise?_____
Do you live alone? No Yes If yes, does family live nearby? No Yes How close? _____
How many years of education did you complete? High School, College, Masters or Other: _____
Are you (please circle) Married Single Divorced Widow Widower
Children (list sex and ages) _____ _____ _____ _____

Are you currently working? No Yes How many hours do you work per day? _____

Please describe your job. _____

_____

ALLERGIES (please list all)

Please list all other surgeries that you have had that are not related to the spine.

REVIEW OF SYSTEMS

Do you have or have you had problems with any of the following: (Circle No or Yes and describe all Yes items)

Eyes	No	Yes _____
Ears, Nose, Throat	No	Yes _____
Lungs, Breathing	No	Yes _____
Heart/Blood Pressure trouble	No	Yes _____
Stomach (ulcer, bleeding, indigestion, etc.)	No	Yes _____
Bowel Movements	No	Yes _____
Kidney Problems	No	Yes _____
Liver Problems	No	Yes _____
Bleeding Problems	No	Yes _____
Balance or Walking Problems	No	Yes _____
Numbness or Tingling	No	Yes _____
Psychological/Nerve Problems	No	Yes _____
Diabetes	No	Yes _____
Cancer	No	Yes _____
Arthritis (Gout, Rheumatoid, Lupus, etc.)	No	Yes _____
AIDS/HIV	No	Yes _____
Tuberculosis/Positive skin test	No	Yes _____
Thyroid Abnormalities	No	Yes _____
Weight gain or loss	No	Yes _____

Are there any diseases that seem to run in your family (cancer, diabetes, heart disease)? No Yes If yes, please list.

Have any of your family members ever had any joint disease such as rheumatoid arthritis, lupus, gout osteoarthritis (wear and tear arthritis), spine disc disease? No Yes If yes, please list.

Do you have any trouble with washing, cleaning, household duties or self care? No Yes If yes, please list.