SAN JOSE NEUROSPINE

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www.SanJoseNeurospine.com • **P:** 408-377-3331

YOUR MEDICAL HISTORY page 1

1 Patient information

Chart #_____

Today's Date _____

Referring Doctor _____

Last Name _____ First Name _____ MI ___

Date of Birth (M/D/Y) _____ Age _____

Sex (M/F) _____ Height _____ Weight _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

2 Your symptoms

Are your symptoms mostly in back, neck or elsewhere? _____

How long have you had these symptoms?

☐ ≤ 6 weeks ☐ ≥ 7 - 12 weeks ☐ 4 months or more

Do you have pain radiating past your knee or elbow? ☐ Yes ☐ No

Does your leg or arm ever go numb? ☐ Yes ☐ No

Have you lost bowel or bladder control? ☐ Yes ☐ No

The pain is: ☐ Constant ☐ It comes & goes

Does your pain wake you up at night? ☐ Yes ☐ No

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

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

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

(If yes, describe) _____

Lost any control over bowel or bladder functions? ☐ Yes ☐ No

(If yes, describe) _____

Any weakness or numbness in an arm or leg? ☐ Yes ☐ No

(If yes, describe) _____

How long can you: _____ Sit _____ Stand _____ Walk

Is your pain the result of a: ☐ Fall ☐ Auto accident ☐ Other (list) _____

3 Current 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

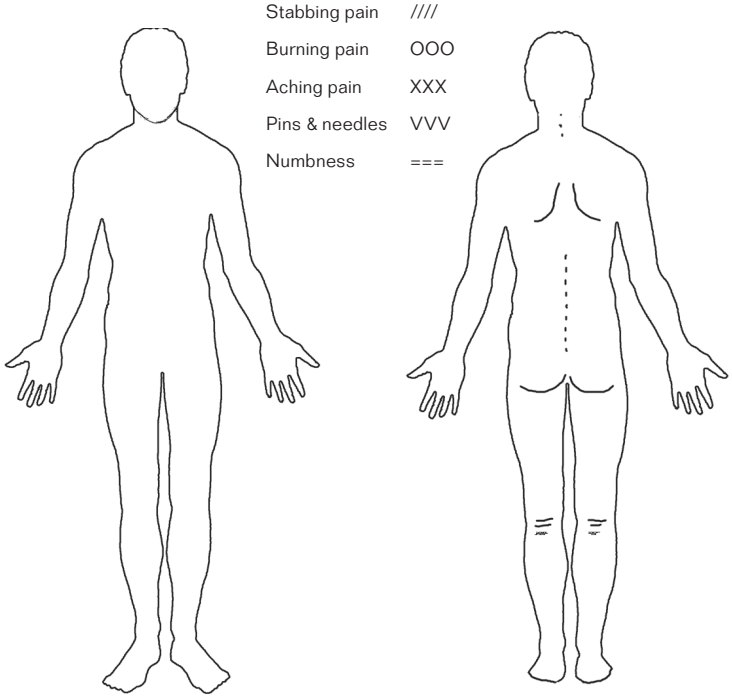
Employer at time of injury _____

4 Your pain

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

FRONT BACK

Stabbing pain	////
Burning pain	OOO
Aching pain	XXX
Pins & needles	VVV
Numbness	===



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

1 2 3 4 5 6 7 8 9 10

no pain extreme pain

Signature _____ Date _____

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5 Previous treatments & tests

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

What treatments did you have? _____

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

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: _____

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

Did you have physical therapy before for your problem? ☐ Yes ☐ No
(If yes, describe) _____

Did this therapy help? ☐ Yes ☐ No
(If yes, describe) _____

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

List any medications you are taking: _____

What other medications have you tried? _____

What do you hope we can accomplish today? _____

What other concerns do you have? _____

6 Your health

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

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

Do you smoke? ☐ Yes ☐ No (If yes, how many packs a day?) _____

Do you drink alcohol? ☐ Yes ☐ No (If yes, how many days a week?) _____

Do you have any of the following medical problems:

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

Other problems: _____

7 Your family history

Do any family members have a history of:

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

Other problems? _____

Signature _____ Date _____