360 SPINE CARE
a Division of Vascular and Interventional Radiology of Community Care Physicians

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Leading the way to better spine health.

MEDICAL HISTORY FORM

Patient Name: _____ DOB: _____ Date: _____

Chief Complaint/Reason for visit: _____

Medication List: Please list all medications, over the counter drugs and supplements you are currently taking.

Name: ex: Folic Acid	**Dosage:** ex: 1mg	**Instructions:** ex: 1 tab daily

Allergy List: Please list all things you are allergic to and how it affects you.

Name: ex: Penicillin	**Reaction:** ex: Nausea

Past Medical History: Please check if you or **your immediate family** have a history of any condition below:

	self	family member		self	family member
Alcoholism	☐	☐ _____	Kidney Disease	☐	☐ _____
Anemia	☐	☐ _____	Liver Disease	☐	☐ _____
Autoimmuue Disorder	☐	☐ _____	Lupus	☐	☐ _____
Cancer	☐	☐ _____	Lung Problems	☐	☐ _____
Congestive Heart Failure	☐	☐ _____	Osteoarthritis	☐	☐ _____
Colitis	☐	☐ _____	Osteoporosis	☐	☐ _____
COPD	☐	☐ _____	Psoriasis	☐	☐ _____
Crohn's Disease	☐	☐ _____	Prostate	☐	☐ _____
Depression	☐	☐ _____	Rheumatoid Arthritis	☐	☐ _____
Diabetes	☐	☐ _____	Scleroderma	☐	☐ _____
GERD	☐	☐ _____	Seizures	☐	☐ _____
Gout	☐	☐ _____	Sexually Transmitted Disease	☐	☐ _____
Glaucoma	☐	☐ _____	Stomach Ulcers	☐	☐ _____
Heart Disease	☐	☐ _____	Stroke	☐	☐ _____
High Cholesterol	☐	☐ _____	Thyroid Disease	☐	☐ _____
High Blood Pressure	☐	☐ _____	Tuberculosis	☐	☐ _____
Hepatitis	☐	☐ _____	Pulmonary Hypertension	☐	☐ _____

Other Major Illnesses: _____

Surgical History: Please list all past operations with dates.

_____

_____

_____

_____

Social History:

Meaningful use of electronic medical records includes the collection of the following demographic information to help identify any health disparities and improve quality of care for all patients.

Gender: (select one) ☐ Male ☐ Female

Marital Status: (select one) ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Other:_____

Race: (select one)
☐ Caucasian ☐ African American ☐ Asian ☐ Native American
☐ Native Alaskan ☐ Native Hawaiian ☐ Pacific Islander ☐ Declined

Ethnicity: (select one) ☐ Hispanic ☐ Non-Hispanic ☐ Declined

Primary Language: (select one) ☐ English ☐ French ☐ Spanish ☐ Other:_____

Occupation:_____ Number of Children:_____
Number of Pregnancies:_____ Number of Miscarriages:_____

Tobacco Use:
☐ Never smoked
☐ Currently smoke every day: Number of packs per day: _____
☐ Currently smoke some days
☐ I have quit smoking: Age when stopped: _____

Alcohol Use:
How many days per week do you drink? _____ How drinks per day? _____
Have you ever had a problem with alcohol? ☐ Yes ☐ No

Illicit / Recreational Drug Use:
Do you use drugs? ☐ Yes ☐ No How often? _____
Have you ever had a problem with illicit drug use? ☐ Yes ☐ No

Exercise:
☐ Yes: How often? _____ ☐ No

Contacts:

Pharmacy:
Retail:_____ Address/Phone:_____
Retail:_____ Address/Phone:_____
Mail order:_____ Address:_____

Names of Physicians/Other Specialists which are treating you:
Name:_____ Phone:_____ Specialty:_____
Name:_____ Phone:_____ Specialty:_____
Name:_____ Phone:_____ Specialty:_____
Name:_____ Phone:_____ Specialty:_____

SYSTEMS REVIEW

Name:_____ DOB:_____

Reason for your visit today:

_____

In the past <u>month</u> have you experience any of the following? Check box if Yes.

- ☐ **Chills**
- ☐ **Fatigue**
- ☐ **Fevers**
- ☐ **Night sweats**
- ☐ **Unintentional weight loss**
- ☐ **Vision loss**
- ☐ **Blurred vision**
- ☐ **Trouble swallowing/dysphagia**
- ☐ **Hearing loss**
- ☐ **Hoarseness**
- ☐ **Jaw pain**
- ☐ **Sinusitis/sinus congestion**
- ☐ **Tinnitus/ringing in ears**
- ☐ **Coughing up blood/Hemoptysis**
- ☐ **Shortness of breath**
- ☐ **Wheezing**
- ☐ **Chest pain**
- ☐ **Leg swelling/Edema**
- ☐ **Palpitations**
- ☐ **Purple fingers in cold/Raynaud's**
- ☐ **Abdominal pain**
- ☐ **Blood in stools**
- ☐ **Constipation**
- ☐ **Diarrhea**
- ☐ **Heartburn**
- ☐ **Nausea**
- ☐ **Vomiting**
- ☐ **Painful urination/Dysuria**
- ☐ **Blood in urine/Hematuria**
- ☐ **Recurrent Urinary Track Infection**
- ☐ **Urinary incontinence**
- ☐ **Increased thirst/Polydipsia**
- ☐ **Extremity numbness**
- ☐ **Difficulty walking/Gait disturbance**
- ☐ **Headache**
- ☐ **Memory loss**
- ☐ **Tingling**
- ☐ **Anxiety**
- ☐ **Depression**
- ☐ **Difficulty sleeping/Insomnia**
- ☐ **Frequent infections**
- ☐ **Hives**
- ☐ **Rash**
- ☐ **Back pain**
- ☐ **Height loss**
- ☐ **Joint pain**
- ☐ **Joint swelling**
- ☐ **Morning stiffness:**
  How long?_____
- ☐ **Muscle cramping**
- ☐ **Muscle cramp/Myalgia**
- ☐ **Neck pain**
- ☐ **Easy bleeding**
- ☐ **Easy bruising**

Have you recently experienced or developed any of the following?

Infection? If so, which type and did you receive antibiotics?

_____

Allergy? To what and what was the reaction?

_____ Were diagnosed with a new medical condition? _____

Did you have any surgery? Who was your surgeon? _____

Were you prescribed any new medications? _____