COMPREHENSIVE SPINE INSTITUTE

Patient History Form

Date Completed____/____/____ **Patient Name:** ______________________________ **DOB**:_____/_____/_____

PCP (Primary Care Physician**):**_________________________________ **Pharmacy:** _______________________

PAST MEDICAL HISTORY: (If yes please specify what type of disease).

Blood Disease	Y N	Immunologic Disorder	Y N
Blood Transfusion	Y N	Kidney Disease	Y N
Bone Disease	Y N	Liver Disease	Y N
Diabetes	Y N	Lung Disease	Y N
Emotional Disorder	Y N	Neurologic Disorder/Stroke	Y N
Endocrine (Glandular) Disease	Y N	Pregnancy #____________	
Heart Disease	Y N	Skin Disease	Y N
High Blood Pressure	Y N	Stomach/Intestinal Disease	Y N
High Cholesterol	Y N	Tuberculosis	Y N

PAST SURGICAL HISTORY:

Surgical Procedure	Date of Surgery	Surgeon / Hospital

OTHER HOSPITALIZATIONS:

Reason	Date	Hospital

CANCER HISTORY:

Type of Cancer and Location	Treatment
	Surgery/Chemotherapy/Radiation
	Surgery/Chemotherapy/Radiation

Comprehensive Spine Institute
1206 Pointe Centre Drive, Suite 110 l Chattanooga Tennessee 37421
Phone: (423) 541-5990 fax: (423) 541-5991

FAMILY HISTORY:

	Living	Deceased	Cause of Death	Age(s)
Father				
Mother				
Brother(s) #				
Sister(s) #				

Please check (√) the following if there is a **positive family history** for any of these disorders:

	Father	Mother	Brother(s)	Sister(s)
Blood Disorder				
Cancer				
Diabetes				
Heart Disease				
Hypertension				
Kidney Disease				
Liver Disease				
Lung Disease				
Neurologic Disorder				
Osteoporosis				
Skin Disease				
Stomach / Intestinal Disorder				

SOCIAL HISTORY: PLEASE CIRCLE

Marital Status: Single Married Separated Divorced Widowed

Number of Children: ________

Currently residing: Alone w/Spouse w/Children w/Significant Other in Assisted Living

w/Caregiver (name:_________________________ in Nursing Home in Rehab Facility

Current residence: One Level Multi level

Current home services: None Oxygen Hospital Bed Sitter Hospice WIC

Home Health for:

Primary Language: English Spanish French German Other:

History of Abuse: None Physical Emotional Financial

Education Completed: Grade School High School GED Associate Bachelor Post Graduate Technical Diploma

Alcohol Use: None Yes # of drinks per day_____ # of drinks per week____

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Tobacco Use: None Yes: # of packs per day_____ # of years_______ **Quit** (how long) ______ mo ______yrs.

History of Substance Abuse: None Alcohol Prescription Medications Illegal Drugs

Work Status Employed FT / PT On sick leave Unemployed Disabled Retired

Occupation: ______________________________________ Employer: _____________________________________

Are you presently off work for a spine condition?: Y N

Have you been on disability for this spinal condition? Y N If so, what is the date last worked? _____/_____/_____

Worker's Compensation: Date of Injury ______/______/______

WC Insurance Company:____

Adjuster:____

Nurse Case Manager:____

Phone #: (_____) ________________ Fax # (_______) _______________________

MEDICATION ALLERGIES

Please specify the name of the medication(s) and the type of reaction the medication causes, such as itching, rash/hives, nausea/vomiting, anaphylactic shock, etc.

Medication Name	Type of Reaction
Iodine Allergy: Y N	**Shellfish Allergy:** Y N
Latex Allergy: Y N	Reaction: / **RAST** Test: Y N

ENVIRONMENTAL AND FOOD ALLERGIES

Please list any food, pollen or environmental allergies that affect you.	
Allergen	Reaction

CURRENT MEDICATIONS:

Please include **ALL** medications, both Prescription and Non-Prescription			
Medication Name / Reason for Medication	Dosage	# of times a day	Prescribing Physician

Please circle Y (Yes) or N (No) to indicate if you currently have the any of the following conditions.

REVIEW OF SYSTEMS (Please specify R/L as indicated)

Constitutional		**Gastrointestinal**	
Good General Health	Y N	Heartburn	Y N
Unexpected Weight Loss	Y N	Indigestion	Y N
Unexpected Weight Gain	Y N	Stomach Pain	Y N
Fevers / Chills	Y N	Diarrhea	Y N
Ophthalmologic		Constipation	Y N
Cloudy vision: **R / L**	Y N	Blood from Rectum	Y N
Redness: **R / L**	Y N		
Drainage from eye: **R / L**	Y N		
Dry eyes	Y N		
Changes in visual field: **R / L**	Y N	**Genitourinary**	
Glasses / Contact lenses	Y N	Blood in Urine	Y N
Ear/Nose/Throat		Change in force of Urination	Y N
Nasal drainage	Y N	Frequent urination	Y N
Changes in sense of smell	Y N	Painful urination	Y N
Hearing Loss: **R / L**	Y N	Cloudy Urine	Y N
Hearing Aid: **R / L**	Y N	Urine Leakage	Y N

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Ringing in Ears	Y N	Urgency of urination	Y N
Difficulty Swallowing	Y N	**Hematologic**	
Sore Throat	Y N	Blood clots	Y N
Cardiovascular		Easy Bruising	Y N
Chest pain with exertion	Y N	Aspirin use	Y N
Palpitations	Y N	NSAID use	Y N
Swelling in **arms / hands**	Y N	Nose Bleeds	Y N
Swelling in **legs / feet**	Y N	Free bleeder	Y N
Coldness in **arms / hands**	Y N		
Coldness in **legs / feet**	Y N		
Respiratory		**Endocrine**	
Wheezing	Y N	Frequent thirst	Y N
Chronic Cough	Y N	Frequent Urination	Y N
Productive Cough	Y N	Hot Flashes	Y N
Shortness of breath	Y N	Flushing	Y N
Sleep Apnea	Y N	Fatigue	Y N
If yes CPAP use?	Y N	Hyperactivity	Y N
Oxygen use	Y N		

Psychiatric		**Immunologic**	
Anxiety	Y N	Frequent infections of:	
Depression	Y N	Lungs	Y N
Mood swings	Y N	Skin	Y N
Dental		Urinary Tract	Y N
Dentures	Y N	**Integumentary (Skin)**	
Cap/Crowns	Y N	Open wounds	Y N
Loose or Chipped Teeth	Y N	Lumps	Y N
Unfilled cavities	Y N	Masses	Y N
Musculoskeletal		**Neurological**	
Back Pain	Y N	Dizziness	Y N
Leg pain: **R / L**	Y N	Headaches	Y N
Difficulty walking	Y N	Seizures	Y N
Neck Pain	Y N	Weakness: **R arm / L arm**	Y N
Arm pain: **R / L**	Y N	Weakness: **R leg / L leg**	Y N
Dexterity problems	Y N	Balance problems	Y N

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Other – Please list any conditions not otherwise noted on this form:

Please list all current physicians, including any chiropractors and nurse practitioners, along with how long you have been seeing them and the reason for seeing them

Name of Provider	Year Care Began	Reason for Care
______________________	__________	______________________
______________________	__________	______________________
______________________	__________	______________________
______________________	__________	______________________
______________________	__________	______________________
______________________	__________	______________________
______________________	__________	______________________

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Patient Signature **Date**

Updated 07/05/2019

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