Baptist
Physician Network
**ORTHOPEDIC SPINE CENTER**
*Performing Sacred Work Every Day*

**Today's date:** _____ **Name:** _____ **Date of Birth:** _____ **Age:** _____
**Height:** _____ **Weight:** _____

**Primary Care Physician:** _____ **Phone:** _____

**Referring Physician:** _____ **Phone:** _____

**Preferred Pharmacy:** _____ **City:** _____ **Phone:** _____

## REASON FOR COMING TO THE DOCTOR TODAY:

**Reason for Today's Visit:** _____

**When did the problem start?** _day(s) ago _week(s) ago _month(s) ago _year(s) ago

**Have you seen another physician for this issue?** _No _Yes, who and when? _____

**Have you had imaging for this problem?** YES NO (XRAYS MRI CT OTHER: _____)

If so, when and where? _____

**Have you had an EMG?** YES NO Where: _____ When: _____

**Have you had Pain Injections?** YES NO Where: _____ When: _____
What type: _____

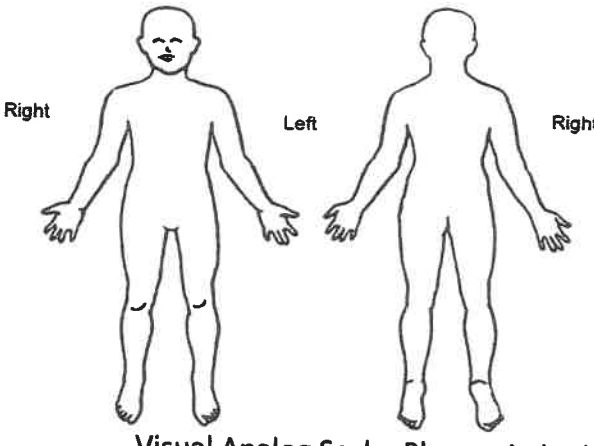
**What treatments have you tried in the past?** None
___Application of ice ____Application of heat ____Physical Therapy ___Home Exercise ____Massage ____Activity Modification ____Brace
___Acupuncture ____Chiropractic Care ____TENS Unit ____Dry Needling ____NSAIDS ____Other Medication ____Surgical Treatment

**What makes your condition feel worse?** _____
**What makes your condition feel better?** _____

## SYMPTOM AND PAIN DIAGRAM:

Please be sure to fill this out as accurately as possible. This will become part of your permanent medical record and will be used to compare your progress throughout your treatment. Mark the area on your body where you feel the described sensations(s). Use the appropriate symbol(s), mark areas of radiating pain, and include all affected areas.

Sharp/Stabbing Pain (xxx) Dull Ache (000) Numbness (---) Burning (///) Pins and Needles (***) Weakness (+++)




### Cervical spine:

**What is the RATIO of neck pain vs arm pain?**(i.e.,80:20) _____
**I have noticed problems with:** __Gait/Walking/Balance __Fine Motor Coordination
___Handwriting is sloppier ___Clumsiness, dropping things more frequently.
___Bowel or Bladder incontinence

### Lumbar Spine:

**What is the ratio of back pain vs leg pain?** (i.e.,80:20) _____
**I have noticed problems with:** __Gait/Walking/Balance _Bowel or Bladder incontinence.

Visual Analog Scale: Please circle the pain levels that most accurately represents your pain.

| | 0 = NO PAIN | | | | | | | | | 10 = UNBEARABLE PAIN |
|---|---|---|---|---|---|---|---|---|---|---|
| Today's Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Worst Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Least Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

## SOCIAL HISTORY:

Please describe your current tobacco/marijuana use habits:

___Never ___Former (I quit____years ago) ____Current **I use:** _Cigarettes _Vaping _Marijuana _Chew/Dip

**Frequency:** _Current every day _Light _Heavy

**Do you drink alcoholic beverages?** ___Yes ____Not Currently _____Never
**If yes, what type and how many servings per week:** _____

**Have you ever used any illicit drugs?** _Yes _Not Currently _____Never
**If yes, what type of drug and how often:** _____

**How would you rate your exercise level?** _Sedentary _Mild _Moderate _Vigorous
**Are you currently working?** YES: ____Full time ___Part time ___With restrictions Occupation: _____

NO: I have not worked since_____ ___Disabled ____Retired ___Unemployed

___Homemaker ___Student ___Other: _____

## MEDICATIONS:

_____I am not currently taking any medications.

List any medications, vitamins, minerals, supplements, and alternative/herbal medications that you are currently taking:

| **Name of Medication** | **Dose** | **Frequency** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## ALLERGY HISTORY:

__**None _NKDA (No Known Drug Allergies)**

Metal Allergies: _No _Yes Agent:_____Reaction: _____
Latex Allergies: _No _Yes Agent:_____Reaction: _____
Medication Allergies: _No _Yes Agent:_____Reaction:_____
Agent:_____Reaction:_____
Agent:_____Reaction:_____
Agent:_____Reaction:_____
Agent:_____Reaction:_____
Agent:_____Reaction:_____
Agent:_____Reaction:_____
IV Contrast Allergies: _No _Yes Agent:_____Reaction:_____
Other Allergies: _No _Yes Agent:_____Reaction:_____
Agent:_____Reaction:_____

## PROBLEM LIST/PAST MEDICAL HISTORY:

**Have you been diagnosed with any of the following (currently or in the past)?**

___Abnormal EKG
___Anemia
___Anesthesia Complication
___Asthma
___Blood Transfusion
___Cancer:_____
___Cirrhosis
___Clotting Disorder/DVT
___COPD
___Coronary Disease
___Diverticulitis
___Fibromyalgia
___GERD
___GI Bleeding
___Glaucoma
___Gunshot Wound
___Head/Brain Injury
___Hearing Loss
___Heart Failure Diastolic
___Depression/Anxiety
___Diabetes Type I/Type II
___Fracture
___Heart Failure
___Hepatitis
___HIV/AIDS
___Hyperlipidemia
___Hypertension
___Hyper/Hypothyroidism
___Kidney Disease
___Heart Valve Disease
___Hemodialysis
___IBS
___Kidney Stones
___Lupus
___Macular Degeneration
___MVA
___Peripheral Artery Disease
___Peritoneal Dialysis
___Liver Disease
___Myocardial Infarct
___Osteoarthritis
___Osteoporosis
___Pulmonary Hypertension
___Seizures
___Sickle Cell Anemia
___Sleep Apnea
___Stroke/TIA
___Substance Abuse
___Pneumonia
___Restless Leg Syndrome
___Rheumatoid Arthritis
___Sciatica
___Scoliosis
___Tuberculosis
___UTIs
___Vascular Disease
___Vertigo
___Angina
___Arrhythmia
___Arthritis
___Atrial Fibrillation
___Bleeding Disorder
___Cataracts
___Chronic Fatigue
___Chronic Pain
___Colon Polyps
___Disabilities
___Obesity
___Gout
___Lyme Disease
___Alzheimer's Disease
___Multiple Sclerosis
___Parkinson's Disease
___Peripheral Neuropathy
___Difficulty Swallowing
___History of MRSA

Other: _____

_____

## PAST SURGICAL HISTORY

_____**None** (Please mark as applicable, date does not need to be exact)

| Procedure | Year | Procedure | Year | Procedure | Year |
|---|---|---|---|---|---|
| _Achilles Repair | _____ | _Arthroscopic Knee – Left | _____ | _Amputation | _____ |
| _Ankle Surgery | _____ | _Arthroscopic Knee – Right | _____ | _Angioplasty | _____ |
| _Thoracic Spine Surgery | _____ | _Knee Replacement – Lt | _____ | _Appendectomy | _____ |
| _Lumbar Spine Surgery | _____ | _Knee Replacement – Rt | _____ | _Cardiac Bypass Surgery | _____ |
| _Elbow Surgery | _____ | _Meniscus – Left | _____ | _Cardiac Pacemaker | _____ |
| _Foot Surgery | _____ | _Meniscus – Right | _____ | _Cardiac Valve | _____ |
| _Hand Surgery | _____ | _Cervical Spine Surgery | _____ | _C-Section | _____ |
| _Hip Replacement – Lt | _____ | _Rotator Cuff Repair – Lt | _____ | _Colostomy/ Colectomy | _____ |
| _Hip Replacement – Rt | _____ | _Rotator Cuff Repair – Rt | _____ | _Gallbladder | _____ |
| _ACL Repair – Left | _____ | _Arthroscopic Shoulder – Lt | _____ | _Gastric Bypass | _____ |
| _ACL Repair – Right | _____ | _Arthroscopic Shoulder – Rt | _____ | _Hernia Repair | _____ |
| _ORIF Fracture – Left | _____ | _Carpal Tunnel Surgery – Lt | _____ | _Small Bowel | _____ |
| _ORIF Fracture – Right | _____ | _Carpal Tunnel Surgery – Rt | _____ | _Thyroidectomy | _____ |

Other:_____

_____

_____

**Have you experienced any adverse events associated with surgery or anesthesia?**

**___No ___Yes, if so, please give pertinent details:** _____

_____

## FAMILY HISTORY:

___Adopted (Unknown History)

Place an "X" under the correct family member with the condition.

| | | | | | |
|---|---|---|---|---|---|
| Alcohol/ Substance Abuse | | | | | |
| Anesthetic Complications | | | | | |
| Asthma | | | | | |
| Broken Bones | | | | | |
| Cancer: | | | | | |
| type: | | | | | |
| Clotting Disorder | | | | | |
| Collagen Disease | | | | | |
| Dementia | | | | | |
| Diabetes Type I | | | | | |
| Diabetes Type II | | | | | |
| Dislocations | | | | | |
| Heart Disease | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Hypertension | | | | | |
| High Cholesterol | | | | | |
| Kidney Disease | | | | | |
| Liver Disease | | | | | |
| Lung/Resp Disease | | | | | |
| Mental Illness | | | | | |
| Osteoporosis | | | | | |
| Rheumatologic Disease/Arthritis | | | | | |
| Scoliosis | | | | | |
| Severe Sprains | | | | | |
| Stroke | | | | | |
| Thyroid Problems | | | | | |
| Anxiety/Depression | | | | | |

Mother Father Sister Brother Child

Mother Father Sister Brother Child

Other:_____

_____