Medical History Form

Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Medical History: **(Please check if you have or had any of the following)**

□ Abuse (physical/mental/sexual/verbal, etc.)	□ Cholesterol (high)	□ Intestinal Disease
□ Abnormal Pap	□ Chronic pain	□ Kidney or Bladder Problems
□ Alcoholism/Drug use	□ Depression/mental disorder	□ Lung Disease
□ Anemia	□ Diabetes	□ Osteoporosis
□ Anxiety/nerves	□ Epilepsy/Seizures	□ Serious Accident/Injury
□ Arthritis	□ Genetic Diseases	□ Sexual Disease/VD
□ Asthma	□ Glaucoma/Cataract	□ Stroke
□ Allergies	□ Gout	□ Thyroid Disease
□ Bleeding disease	□ Headaches/Migraine	□ Tuberculosis
□ Blood transfusion	□ Heart Disease	□ Ulcers/Stomach Disease
□ Blood clots	□ Hepatitis (any)	
□ Cancer/Tumor	□ High blood pressure	

Surgical History & Date / Age If Known: _____No Surgeries

_____

_____

Do you have an advanced directive on file? Yes No

Hospitalizations: _____No Past Hospitalizations

Date/Age: _____ Reason:_____

Date/Age: _____ Reason:_____

Family History: **History Of**:

Father:	Alive or Deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Unknown
Mother:	Alive or Deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Unknown
Child:	Alive or Deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Unknown
Child:	Alive or Deceased	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Unknown

Social History:

Tobacco Use: Yes No ☐ Former ☐ Never Drug Use: Yes No Alcohol Use: Yes No

Sexually Active: Yes No Ever had a Sexually Transmitted Disease? Yes No

Social Functioning (Wellness exams only)

During the past 4 weeks, was someone available if you needed and wanted help? For example, if you felt very nervous, lonely, or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself. □ Yes, as much as I wanted □ Yes, quite a bit □ Yes, some □ Yes, a little □ No, not at all □ I choose not to answer

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? (Check all that apply) □ Yes, it has kept me from medical appointments or getting my medications. □ Yes, it has kept me from non-medical appointments, meetings, work, or getting things I need. □ No. □ I choose not to answer.

Medications Currently Taking (List) Name / Dosage / How Often:

_____

_____

_____

Allergies: to medications, food, or latex (List): _____

FEMALES ONLY: Is it possible that you may be pregnant? YES NO Date of Last Menstrual Cycle: _____

Immunizations Up-To-Date? ___Current to my knowledge ___Not up-to-date ___Unknown (will discuss w/provider)

Injured at Work: YES NO Date/Time of Injury: _____

Name:_____ Date:_____

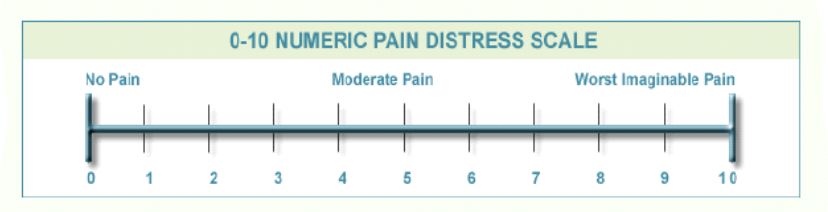
Baylor Scott & White
Texas Brain and Spine Institute

Overall Health Status:

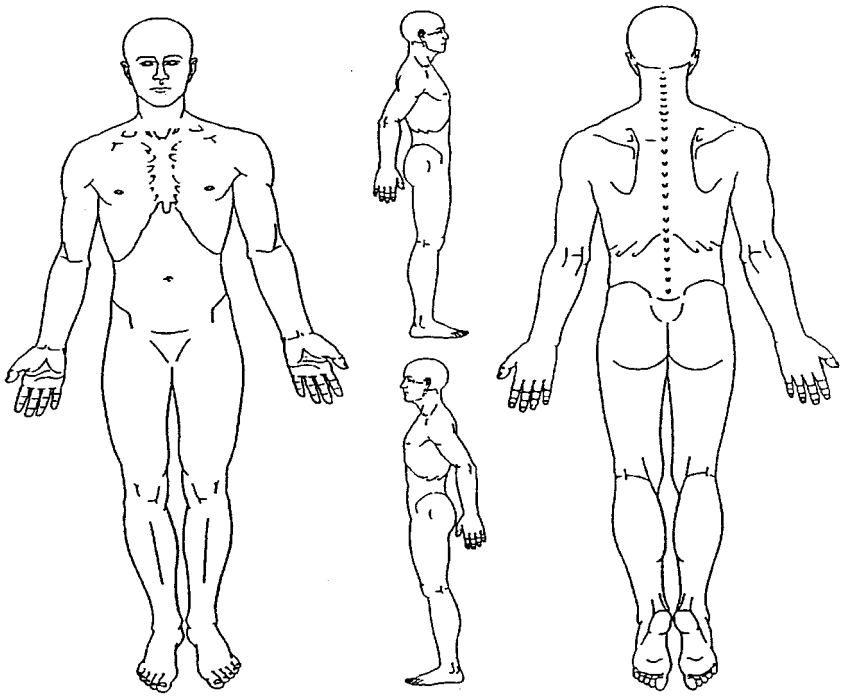
I feel my overall state of health is: ❑ Good ❑ Fair ❑ Poor

Height: _____ Weight: _____ ❑ I am right-handed ❑ I am left-handed

Pain Scale: Using the scale below, what number would you rate your ***current*** pain? _____



USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR PAIN		
A = ACHE	B = BURNING	C = STABBING
N = NUMBING	P = PINS & NEEDLES	O = OTHER



1. My pain is in my: _____
2. Select one of the following:
   - ❑ My problem is chronic. It began at age: _____
   - ❑ My pain began (date and year): _____
3. Is this related to a recent injury? ❑ Yes ❑ No ❑ Possibly
   Is the injury work related? ❑ Yes ❑ No Date of injury? _____
   Date stopped work? _____
4. Please explain how it happened: _____

Name:_____ Date:_____

I also have the following problems:

- ❑ My pain awakens me from sleep
- ❑ My pain is worse at night
- ❑ I have numbness/tingling in my arms
- ❑ I have numbness/tingling in my hands
- ❑ I drop items after I pick them up
- ❑ I am off-balance when I walk
- ❑ I stumble/fall frequently or run into walls
- ❑ My arms/legs are weak because they hurt
- ❑ My legs feel weak or hurt when I walk too far:
  - ❑ This is relieved by sitting
  - ❑ This is relieved by stopping and standing
- ❑ I can walk:
  - ❑ Less than a block
  - ❑ 1-2 blocks
  - ❑ More than 3 blocks
- ❑ I awaken at night with my hands asleep
- ❑ My hands go to sleep while:
  - ❑ Driving
  - ❑ Using a computer mouse
  - ❑ Using a telephone or blow dryer
- ❑ I have weakness in my:
  - ❑ Right leg ❑ Left leg
- ❑ I have numbness/tingling in my:
  - ❑ Right leg ❑ Left leg
  - ❑ Right foot ❑ Left foot
- ❑ I have trouble with my bladder control
  - ❑ Can't empty my bladder
  - ❑ Loss of control (accidents)
- ❑ I have trouble with my bowels
  - ❑ Constipation
  - ❑ Loss of control (accidents)

Previous Treatment and Medication <u>for This Condition</u>: ❑ None

I have been prescribed for this condition:	With how much relief? None	A Little	A Lot
❑ Medications:			
❑ Anti-inflammatories: _____	❑	❑	❑
_____	❑	❑	❑
_____	❑	❑	❑
❑ Muscle relaxers: _____	❑	❑	❑
_____	❑	❑	❑
_____	❑	❑	❑
❑ Pain medication: _____	❑	❑	❑
_____	❑	❑	❑
_____	❑	❑	❑
❑ Steroid Dose Pack/Medrol/Prednisone: _____	❑	❑	❑
_____	❑	❑	❑
_____	❑	❑	❑
❑ Physical Therapy	❑	❑	❑
❑ Traction	❑	❑	❑
❑ Exercises	❑	❑	❑
❑ Spinal Injections	❑	❑	❑
❑ Manipulation: Chiropractor's Name: _____	❑	❑	❑
❑ Heat ❑ Cold	❑	❑	❑

Name:_____ Date:_____

- I have seen other doctors for my condition: ❑ Yes ❑ No

  If Yes, on what date?_____By whom? _____Where?_____

- I have had surgery before for this same type of problem. How long ago?_____

  What type of surgery?_____Physician who performed surgery?_____

- I have had the following tests: ❑ Plain X-Rays ❑ CAT Scan ❑ MRI ❑ Myelogram ❑ Discogram ❑ EMG

The following actions make me feel:

	Better	Worse		Better	Worse
Bed rest	❑	❑	Standing	❑	❑
Massage	❑	❑	Sitting	❑	❑
Stretching/Popping	❑	❑	Walking	❑	❑
Bending Backwards/Forwards	❑	❑	Heat	❑	❑
Bending to the left	❑	❑	Ice	❑	❑
Bending to the right	❑	❑	Sneezing/Coughing	❑	❑
Straining to go to the bathroom	❑	❑	Changing Positions	❑	❑

Work Essentials:

My job requirements are:

❑ I am not currently employed

❑ Heavy Lifting – over 60 lbs with frequent bending and stooping
❑ Medium Lifting – between 30-50 lbs
❑ Light Lifting – 10-20 lbs

❑ Sedentary – mostly sitting with very little lifting
❑ My job is highly stressful & it makes me tense