OKLAHOMA CENTER FOR
SPINE & PAIN
SOLUTIONS

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PATIENT HISTORY

Today's Date: _____

Last Name: _____ First Name: _____

Height: _____ Weight: _____ Age: _____ Sex: _____

Referred By:

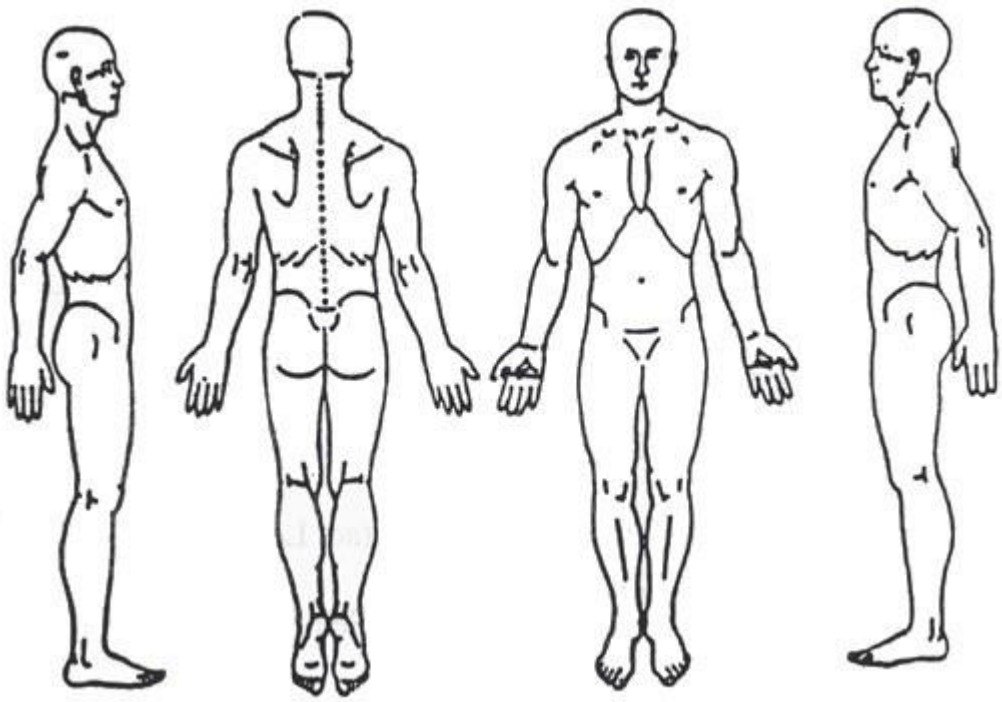
_____

CHIEF COMPLAINTS: **DATE THE PROBLEM BEGAN**

1. _____
2. _____
3. _____
4. _____

1. SHADE IN THE AREAS ON THE DIAGRAM WHERE YOUR PAIN IS LOCATED.

Mark numbness with: ====== Pins and needles with: ooooo Burning with: xxxxx Stabbing with: /////



HISTORY OF PRESENT ILLNESS

2. WHERE IS YOUR PAIN LOCATED? (Check all that apply)

Low Back _____ % Mid Back _____ % Upper Back _____ % Neck _____ %

Left Buttock _____ % Right Buttock _____ % Left Leg _____ % Right Leg _____ %

Left Shoulder _____ % Right Shoulder _____ % Left Arm _____ % Right Arm _____ %

_____% Other/ Explain _____

3. IS YOUR PAIN THE RESULT OF AN ACCIDENT? _____ Yes _____ No Date of Accident _____

Accident at Work _____ Accident at Home _____ Motor Vehicle Accident _____

Are you involved in any litigation involving your injury? ____ Yes ____ No If so, who is your lawyer? _____

4. IS YOUR PAIN: _____Constant _____Intermittent

5. ON A RATING SCALE OF 1 TO 10 HOW SEVERE IS YOUR PAIN? (10 being the most excruciating)

Back Pain: _____ Neck Pain: _____ Arm Pain: _____ Leg Pain: _____

Does your pain wake you up or keep you from falling asleep? _____ Yes _____ No

6. DOES ANY OF THE FOLLOWING MAKE YOUR PAIN FEEL BETTER?

_____ relaxation _____ sitting _____ standing _____ lying down _____ heat

_____ cold _____ walking/exercise _____ alcoholic drinks _____ oral medications _____ sexual activity

_____ Other Explain: _____

7. DOES ANY OF THE FOLLOWING MAKE YOUR PAIN FEEL WORSE?

_____ coughing/Sneezing _____ sitting _____ standing

_____ lying down _____ walking/exercise _____ sexual activity

_____ Other Explain: _____

8. HAVE YOU HAD ANY OF THE FOLLOWING FOR THIS PROBLEM?

____ Lumber MRI _____ Cervical MRI _____ X-Rays _____ Discogram _____ EMG _____ CT Scan _____ Myelogram

9. HAVE YOU HAD ANY PREVIOUS TREATMENT FOR THIS PROBLEM?

_____Physical Therapy Did it: _____ Help _____ Hurt _____ Neither

_____Epidural Injections Did it: _____ Help _____ Hurt _____ Neither

_____Surgery Explain type: _____

PAST MEDICAL HISTORY
(Please check all that apply)

_____ Heart Disease	_____ Heart Attack	_____ Blood Clots	_____ Seizures
_____ Hepatitis	_____ Thyroid Condition	_____ Bleeding disorder	_____ Tuberculosis
_____ Rheumatoid Arthritis	_____ High Blood Pressure	_____ Easy Bruising	_____ Heart Failure
_____ Osteoarthritis	_____ Stroke/TIA	_____ Asthma	_____ Ulcers
_____ Scoliosis	_____ Gout	_____ Cancer	_____ HIV/AIDS
_____ Diabetes	Other/Explain:_____		

Please list all previous surgeries and dates:

_____

_____

_____

_____

_____

Please list your allergies:

_____

_____

Do you have any weakness? _____ Yes _____ No

Where is the weakness located?

_____ Left Arm _____Right Arm _____Left Leg _____Right Leg _____Left Hand _____Right Hand

Has the weakness increased over the last six months? _____ Yes _____ No

REVIEW OF SYSTEMS
(Check all that apply)

___ Loss of consciousness	___ Tremors	___ Paralysis	___ Night sweats
___ Shortness of breath	____Swelling	___ Chest Pains	___ Heart palpitations
___ Headaches	___ Cough	___ Difficulty Walking	___ Weight loss
___ Problem with balance	___ Loss of bowel/bladder control	___ Other _____	

CURRENT MEDICATIONS:

_____ _____ _____

_____ _____ _____

_____ _____ _____

FAMILY MEDICAL HISTORY: (Please check all that are found in your family)

	FATHER	MOTHER	SISTER	BROTHER	GRANDPARENTS
Allergies					
Arthritis					
Asthma					
Cancer					
Diabetes					
Epilepsy					
High Blood Pressure					
Other (specify)					

SOCIAL MEDICAL HISTORY:

Currently Working? _____ Yes _____ No If no, last date worked? _____

Current Occupation: _____

Are you? _____ Married _____ Divorce _____ Single

Do you smoke? _____ Yes _____ No If yes, # of Packs/day _____ How long have you smoked? _____

Do you drink alcohol? _____ Yes _____ No Number of Drinks _____ Frequency _____

Any recreational drug use? _____ Yes _____ No Type? _____ Other information: _____

Patient Signature: _____ Date: _____

Print Name: _____

Physician/P.A. Signature: _____ Date: _____