Neurological Surgery and Spine Surgery, S.C.

Medical History Form

Date: **Age:**
Name: **Gender**:M/F

Referring Doctor: **Height:**
Weight:

Please describe your symptoms:

When did your symptoms start?

Are your symptoms (circle one): constant, periodic

Have you had similar symptoms previously?

Which position makes the pain worst (circle one):
Sitting, standing, lying down

Which position makes the pain better (circle one):
Sitting, standing, lying down

What else makes the pain worse?

What else makes the pain better?

Past Medical History
1.
2.
3.

Past surgical History
1.
2.
3.

Allergies:

Medications:

Social History (circle all that applies)
Smoking: none or …..packs x …..years
Alcohol: none, social, daily
Living with: spouse, self, parents, kids

Family History (live, dead, include medical problems)
1. Father:
2. Mother:
3. Sibling:
4. Sibling:

Review of system (circle all that applies):

General: fever, chills, weight loss, weight gain
Muscle/Joints: pain, weakness, decreased ROM
Neurological: Weakness, numbness, tingling
Urologic: urinary incontinence,difficulty voiding
Psychiatric: depression, anxiety
Others:……

Work (circle one): Retired, Disabled, Working(fill the rest)

Place of employment:

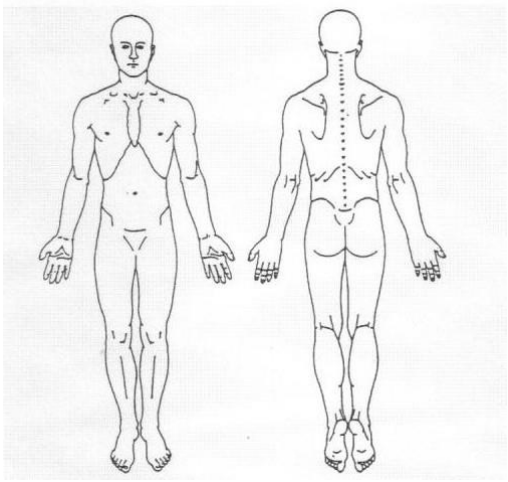
Job Description:

Circle which applies:
Heavy duty (50-100 lbs)
Medium duty (20-50 lbs)
Light duty (up to 20 lbs)
Desk work (less than 10 lbs)

Prior Treatments (circle all applies)

-Bed Rest (No relief, some relief, good relief)
-Physical therapy (No relief, some relief, good relief)
-Chiropractic (No relief, some relief, good relief)
-Cortisone injection (No relief, some relief, good relief)
-Brace (No relief, some relief, good relief)

Shade the affected area with pain



Pain Severity (circle one): 0 1 2 3 4 5 6 7 8 9 10