Name_____ Age _____Ht _____ Wt _____
Reason For Today's Visit _____

Please Leave This Column Blank for Physician Comments

Date of Injury/Onset _____ Where _____

Are You Working Now? Y N Date Last Worked _____Occupation_____

How Did This Happen? _____

ALLERGIES: (Please indicate your reaction to the right of the medication)

___ None
___ Anesthesia _____
___ Aspirin _____
___ Codeine _____
___ Demerol _____
___ Erythromycin _____
___ Iodine _____
___ Morphine _____
___ Penicillin _____
___ Sulfa _____

Other _____

MEDICATIONS (Presently Taking):_____

_____

YOUR MEDICAL HISTORY:

___ Aids/HIV
___ Anemia
___ Arthritis
___ Back Problems
___ Bleeding Disorder
___ Bone Disease
___ Bronchitis
___ Cancer
___ Diabetes
___ Epilepsy/Seizures
___ Emphysema
___ Gout
___ Heart Disease
___ Heart Murmur
___ Herpes/Shingles
___ Hepatitis/Jaundice
___ Hiatal Hernia/Reflux
___ High Blood Pressure
___ Infections
___ Kidney Disease
___ Meningitis
___ Migraine Headaches
___ Nervous Breakdown
___ Neurologic Disease
___ Rheumatic Fever
___ Sleep Apnea – CPAP?
___ Tuberculosis
___ Ulcers

Other: _____

SURGICAL HISTORY:

Type of Surgery	Date	Where	Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

REVIEW OF SYSTEMS:

Any numbness, tingling, burning, or other nerve problem? _____
Any fever, chills, appetite loss, unexpected weight loss? _____

FAMILY HISTORY (i.e.: heart problems, diabetes, high blood pressure, cancer):

_____

_____

SOCIAL HISTORY: Do you smoke? Yes No If so, how much? _____
Do you drink alcohol? Yes No If so, how much? _____

This document reviewed by _____ , M.D. on _____ (Date)

Updated by patient _____ on _____ (Date)

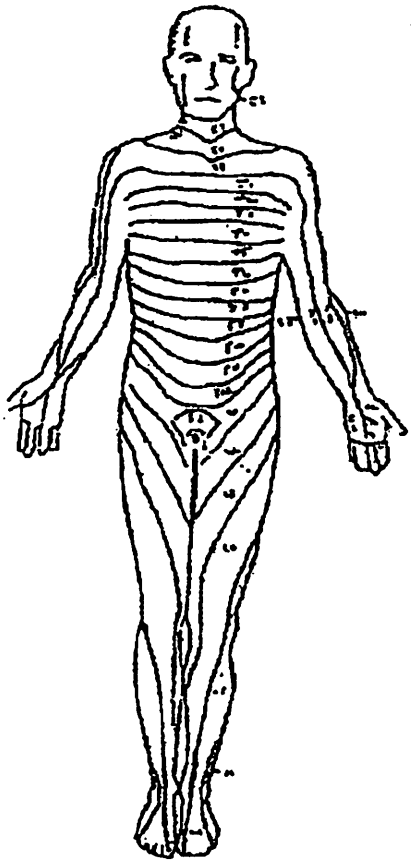
NEVADA Orthopedic & Spine Center

ACCT # _____

DR # _____

TO BE COMPLETED BY PATIENT

NAME _____ DATE _____



PAIN LOCATION -- SHADE IN PAINFUL AREA

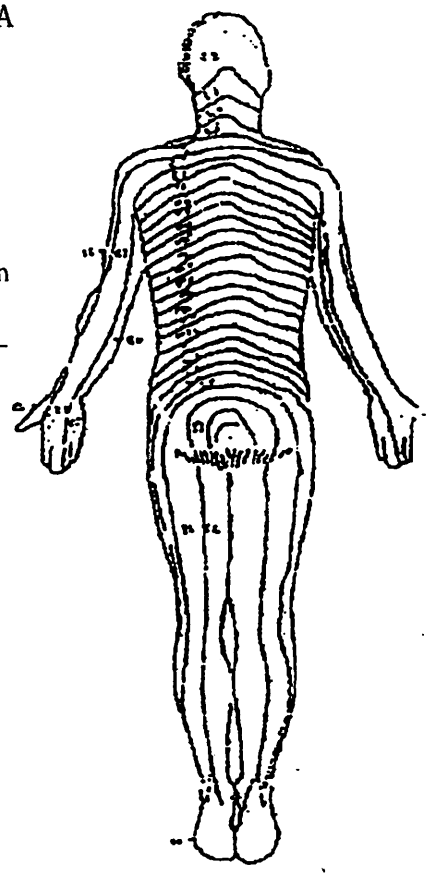
WHICH WORDS DESCRIBE YOUR PROBLEM
PLEASE CHECK (✔)

___ Ache ___ Burning ___ Hot

___ Pins / Needles ___ Stabbing ___ Cold

___ Numbness ___ Pressure ___ Vibration

___ Other _____



On a Scale of 0 (no pain) to 10 (worst possible pain) how bad is your pain:

Now 0 1 2 3 4 5 6 7 8 9 10

At its worst 0 1 2 3 4 5 6 7 8 9 10

Is the pain in your arm(s):

Worse than your neck _____

Same as your neck _____

Less than your neck _____

For A 100% Total Please Divide Your Pain

Neck Pain _____ %

Arm Pain _____ %

Is the pain in your leg(s):

Worse than your back _____

Same as your back _____

Less than your back _____

For A 100% Total Please Divide Your Pain

Back Pain _____ %

Leg Pain _____ %

How long can you:

Sit? _____ minutes

Stand? _____ minutes

Ride in Car _____ minutes

How far can you walk _____ blocks

Please List Any Activities That Make Your Problem:

Worse _____

Better _____

Patient / Guarantor Signature _____