NOVUS SPINE & PAIN CENTER

The First Step To A Pain Free Life

Patient Medical History

Patient Name: _____ Chart #: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: _____ Primary Care Physician: _____

How were you referred to us? ☐ Self ☐ Work Comp ☐ Chiroprator ☐ Primary Care Physician

What is the main reason for this visit? _____

On a scale of 0 to 10 what number would you give your pain today? _____ (0 no pain, 1-3 mild, 4-6 moderate, 7-10 severe)

PAST HEALTH HISTORY OF PATIENT - Please check **Y** or **N** for each condition listed below. **Do not leave any blanks.**

Metabolic Disease
- Diabetes ☐Y☐N
- High Blood Pressure ☐Y☐N
- Thyroid Disease ☐Y☐N
- Osteoporosis ☐Y☐N

Pulmonary Disease
- Pneumonia ☐Y☐N
- Asthma ☐Y☐N
- COPD ☐Y☐N
- Tuberculosis ☐Y☐N

CNS Disease
- Stroke ☐Y☐N
- Seizure ☐Y☐N

Cardiac Disease
- Heart Attack ☐Y☐N
- Angina ☐Y☐N
- Heart Murmur ☐Y☐N
- Arrhythmia ☐Y☐N
- Valve Problems ☐Y☐N

Psychiatric Disease
- Depression ☐Y☐N
- Schizophrenia ☐Y☐N
- Bipolar Disorder ☐Y☐N

GI Disease
- Ulcer ☐Y☐N
- Gall Bladder ☐Y☐N
- Hernia ☐Y☐N
- GI Bleed ☐Y☐N
- Obstruction ☐Y☐N

Urologic Disease
- Urinary Tract Infection ☐Y☐N
- Kidney Stone ☐Y☐N
- Dialysis ☐Y☐N

Cancer
- Location _____
- Year Diagnosed _____
- Reoccurrence ☐Y☐N
- Current Treatment ☐Y☐N

Infections
- After Surgery ☐Y☐N
- Venereal Disease ☐Y☐N
- Hepatitis ☐Y☐N
- AIDS ☐Y☐N
- HIV Positive ☐Y☐N
- Osteomyelitis ☐Y☐N

Blood Disorders
- Anemia ☐Y☐N
- Clotting Problems ☐Y☐N
- Hemophilia ☐Y☐N

Arthritis ☐Y☐N
- Rheumatoid ☐Y☐N
- Osteoarthritis ☐Y☐N
- Gout ☐Y☐N

Miscellaneous
- Blood Clots ☐Y☐N
- Thrombophlebitis ☐Y☐N
- Prior Blood Transfusion ☐Y☐N

Explain any other conditions not listed above that you have been diagnosed with: _____

_____

SURGICAL PROCEDURES (include approximate dates): ☐ **NONE**

_____ _____

_____ _____

_____ _____

_____ _____

Have you ever had a problem with anesthesia? ☐ No ☐ Yes If yes, explain _____

ALLERGIES: ☐ **NONE**

Medication / Other	Reaction	Severity of Allergy - circle level of severity
_____	_____	Mild ☐ Moderate ☐ Severe ☐ Intolerant ☐
_____	_____	Mild ☐ Moderate ☐ Severe ☐ Intolerant ☐
_____	_____	Mild ☐ Moderate ☐ Severe ☐ Intolerant ☐
_____	_____	Mild ☐ Moderate ☐ Severe ☐ Intolerant ☐
_____	_____	Mild ☐ Moderate ☐ Severe ☐ Intolerant ☐

Reaction Examples: *Unknown, Breathing Difficulty, Nausea, Rash, Anaphylaxis, Vomiting, Diarrhea, Hives, Dizziness*

CURRENT MEDICATIONS: ☐ **NONE** *Include medications prescribed by a physician, Over-the-Counter (OTC), Herbal Supplements and Vitamins.*

Medication & Dosage	Prescribing Physician	Medication & Dosage	Prescribing Physician
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	