SOS
SPINE AND ORTHOPEDIC SOLUTIONS

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For Office use only: Account #_____

PATIENT MEDICAL HISTORY AND PAIN FORM

Full Name: _____Todays Date:_____

Age: _____ Date of Birth: _____ Occupation: _____

VITALS: _____

Height: _____ Weight: _____

Chief Complaint:

☐ Low Back Pain ☐ Neck Pain ☐ Shoulder Pain ☐ Hip Pain ☐ Leg Pain ☐ Knee Pain

☐ Left ☐ Right ☐ Bilateral

HISTORY AND PRESENT ILLNESS:

Who referred you?_____ Name of Primary Care Doctor :_____

When did your symptoms begin?_____

Is this a work related? ☐ Yes ☐ NO Other Injury? ☐ Yes ☐ NO MVA? ☐ Yes ☐ NO

If this was a work injury, what was the date of injury? _____

If this was a work injury, was the injury reported to your employer? ☐ Yes ☐ NO

Do you have: ☐ Numbness ☐ Tingling ☐ Weakness

On a scale of 1 – 10, How bad is your pain? (10 is worst pain)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

TELL US WHAT TEST YOU HAVE HAD:

☐ MRI Where? _____ When _____

☐ X-ray Where? _____ When _____

☐ CT Scan Where? _____ When _____

☐ EMG Where? _____ When _____

PATIENT MEDICAL HISTORY AND PAIN FORM

CHECK THE TREATMENT YOU HAVE HAD FOR THIS CONDITION.	DID IT HELP?	
☐ Medication	☐ Yes	☐ No
☐ Physical Therapy	☐ Yes	☐ No
☐ Injections	☐ Yes	☐ No
☐ Surgery	☐ Yes	☐ No

MEDICATIONS:

Pharmacy Name: _____Phone: _____

List the name of all medication that you are taking, including over the counter medications, the dosage, and frequency

NAME OF MEDICATION	DOSAGE	FREQUENCY
Example: Mobic	7.5 mg	1 tablet twice a day

MEDICAL HISTORY: Please check all boxes below of the conditions that apply to you.

☐ No Previous Medical Problems

☐ Asthma	☐ Epilepsy	☐ Lung Problems	☐ Stroke
☐ Blood Clots	☐ Gout	☐ Surgery	☐ Thyroid
☐ Cancer	☐ Heart Attack	☐ Surgery	☐ Surgery
☐ Depression	☐ High Blood Pressure	☐ Surgery	☐ Ulcers
☐ Diabetes	☐ High Chloesterol	☐ Surgery	☐ Other _____
☐ Drug Dependency	☐ Kidney Problems	☐ Sleep Anea	

PATIENT MEDICAL HISTORY AND PAIN FORM

ALLERGIES: Please list the names of ALL drug allergies that you have.

☐ No Known Drug Allergies

NAME OF DRUG	DESCRIBE YOUR REACTION TO THIS MEDICATION

PAST SURGICAL HISTORY: Please check all boxed below of the surgeries that apply to you.

☐ No Past Surgical History

PREVIOUS SURGERY	DATE	HOSPITAL	DOCTOR
☐ Appendectomy			
☐ Cesarean Section			
☐ Coronary Artery Bypass			
☐ Gallbladder			
☐ Hysterectomy			
☐ Inguinal Hernia Repair			
☐ Joint Surgery			
Which Joint _____			
☐ Spine Surgery			
☐ Tonsillectomy			
☐ Other _____			

PATIENT MEDICAL HISTORY AND PAIN FORM

FAMILY MEDICAL HISTORY: Please check the box below that applies to the patient's blood relatives.

Please list relationship to the patient.

ILLNESS	RELATIONSHIP	ILLNESS	RELATIONSHIP
☐ Arthritis		☐ Heart Disease	
☐ Cancer		☐ Osteoporosis	
☐ COPD		☐ Sleep Apnea	
☐ Diabetes		☐ Stroke	

SOCIAL HISTORY: Please check all boxes that apply to you.

Tobacco: ☐ Yes ☐ No Packs per day:_____ Years: _____

Age Started: _____ Age Stopped: _____

Alcohol: ☐ Yes ☐ No Packs per day:_____ Years: _____

Age Started: _____ Age Stopped: _____

Please add any additional pertinent information:

PATIENT MEDICAL HISTORY AND PAIN FORM

GENERAL/CONSTITUTIONAL					
Fever/Chills	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Night Sweats	☐ Yes	☐ No	Weight loss or gain	☐ Yes	☐ No
SKIN					
Color Changes	☐ Yes	☐ No	Rashes	☐ Yes	☐ No
NEUROLOGICAL					
Gait Abnormality	☐ Yes	☐ No	Numbness	☐ Yes	☐ No
Weakness	☐ Yes	☐ No			
RESPIRATORY					
Pain with Inspiration	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
CARDIOVASCULAR					
Shortness of Breath with Activity	☐ Yes	☐ No	Swelling	☐ Yes	☐ No
GASTROINTESTINAL (DIGESTION)					
Stomach Ulcers	☐ Yes	☐ No	Change in Bowel Habits	☐ Yes	☐ No
Abdominal Pain	☐ Yes	☐ No	Difficulty Swallowing	☐ Yes	☐ No
GENITOURINARY (URINATION)					
Difficulty Urinating	☐ Yes	☐ No	Incontinence	☐ Yes	☐ No
PERIPHERAL VASCULAR					
Calf Pain with Walking	☐ Yes	☐ No	Cold Extremities	☐ Yes	☐ No
MUSCULOSKELETAL (MUSCLES ADN BONES)					
Back Pain	☐ Yes	☐ No	Neck Pain	☐ Yes	☐ No
Muscle or Joint Pain	☐ Yes	☐ No	Night Pain	☐ Yes	☐ No
HEMATOLOGIC					
Easy Bleeding	☐ Yes	☐ No	Easy Bruising	☐ Yes	☐ No
PSYCHIATRIC					
Depression	☐ Yes	☐ No	Substance Abuse	☐ Yes	☐ No

INTERNAL USE ONLY

Reviewed By: _____ Date: _____