COASTAL ORTHOPEDICS

SPINE ESTABLISHED PATIENT MEDICAL HISTORY UPDATE

Date of visit: ____ /____ /____ **Who are you seeing today:_____**

YOUR INFORMATION

Full name: _____

Date of birth: ____ /____ /_____

Height: _____ **Weight:** _____

Hand dominance: ☐ Right ☐ Left ☐ Ambidextrous

Primary care physician:

PLEASE INDICATE ANY NEW MEDICATIONS SINCE LAST VISIT

Are you currently, or will you be initiating, the use of Medical Marijuana for any reason? ☐ Yes ☐ No

Are you taking Aspirin or any other blood thinners? ☐ Yes ☐ No

☐ Yes ☐ No **I consent to securely pull my medications from the pharmacy database, and reconcile with the Medical Assistant**

List all the medications you take, both prescription & nonprescription below:

☐ **No medications to list** ☐ **See attached list of medications**

Medication or Brand Name	Dose	Medication or Brand Name	Dose

YOUR ALLERGIES

☐ **No new allergies** **Indicate all the allergies you have to medications and/or food & describe reaction below:**

Common reactions include – Anaphylaxis (Life Threatening), Hives, Itching, Nausea/Vomiting, Trouble Breathing

PLEASE INDICATE ANY NEW MEDICAL HISTORY SINCE LAST VISIT

☐ **No new relevant medical history**

☐ Hypertension	☐ Kidney disease	☐ Obesity	☐ AIDS/HIV
☐ Heart disease: _____	☐ Diabetes – I or II	☐ Peripheral vascular disease	☐ Ulcers
☐ Osteoarthritis	☐ Osteoporosis	☐ Anxiety	☐ DVT/blood clots
☐ Rheumatoid arthritis	☐ Cancer– Type: _____	☐ Depression	☐ Stroke

Any additional medical history information:

SURGICAL HISTORY SINCE LAST VISIT

☐ **No new surgical history**

☐ Hip replacement – RT/LT	Date: ____/____/_____	☐ Fracture – Type: _____	Date: ____/____/_____
☐ Knee replacement – RT/LT	Date: ____/____/_____	☐ Pacemaker	Date: ____/____/_____
☐ Shoulder/rotator cuff – RT/LT	Date: ____/____/_____	☐ Open heart/by-pass	Date: ____/____/_____
☐ Carpal tunnel – RT/LT	Date: ____/____/_____	☐ Spine – type/level: _____	Date: ____/____/_____
☐ Arthroscopy – Type: _____	Date: ____/____/_____	☐ Other: _____	Date: ____/____/_____

Any additional surgical information:

DIAGNOSTIC HISTORY SINCE LAST VISIT

Study	Date	Results
X-RAYS	_____ /_____ /_____	
MRI/CT	_____ /_____ /_____	
EMG/nerve conduction studies	_____ /_____ /_____	
Myelogram	_____ /_____ /_____	
Bone scan / DEXA scan	_____ /_____ /_____	

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SPINE ESTABLISHED PATIENT MEDICAL HISTORY UPDATE

YOUR SOCIAL HISTORY

Tobacco Use: ☐ Current ☐ Former ☐ Never **If Current**, have you ever tried to quit? ☐ Yes ☐ No

Type: _____ Packs/Day: _____ Years used: _____

Alcohol Use: ☐ Yes ☐ No ☐ Former **If Yes**, select type: ☐ Beer ☐ Wine ☐ Liquor

Frequency: _____ Amount per sitting: _____ Last drink: _____

Which of the following drugs or substances. if any, have you used in the PAST? (Please check all that apply)

☐ None ☐ Cocaine ☐ Heroin ☐ Marijuana ☐ Other:_____

Are you PRESENTLY using any of the following drugs or substances? (Please check all that apply)

☐ None ☐ Cocaine ☐ Heroin ☐ Marijuana ☐ Other:_____

REVIEW OF SYSTEMS

☐ **All Negative Below** **Check if you have any of the following:**

General	Cardiovascular	Metabolic	Skin
☐ Fever	☐ Heart murmur	☐ Cold intolerance	☐ Rash
☐ Weakness	☐ Leg swelling/edema	☐ Heat intolerance	☐ Skin infections
☐ Weight gain/loss (circle one)	☐ Syncope/fainting		☐ Skin lesions
Ears, Nose & Vision	**Gastrointestinal (GI)**	**Neurological**	**Blood Disorders**
☐ Blurred vision	☐ Constipation	☐ Difficulty walking	☐ Bleeding
☐ Facial pain	☐ Diarrhea	☐ Dizziness	☐ Bruising
☐ Headache	☐ Nausea	☐ Poor coordination	
☐ Vertigo/dizziness	☐ Vomiting	☐ Muscle weakness	
Respiratory	**Urinary**	**Psychiatric**	**Immune System**
☐ Dyspnea (difficulty breathing)	☐ Dysuria (difficulty urinating)	☐ Anxiety	☐ Asthma
☐ Recent infections	☐ Frequent urination	☐ Depression	☐ Environmental allergies
☐ Wheezing	☐ Hematuria (blood in urine)	☐ Insomnia	☐ Food allergies

YOUR ATTESTATION

I attest that the information provided above is complete & accurate as it will be utilized as part of my care and treatment plan.

Patient signature: **Date:** ____ /____ /____

If minor, guardian signature: **Date:** ____ /____ /____

COASTAL ORTHOPEDICS

SPINE CONDITION

Patient name: _____ Date of birth ___/___/_____ Today's date___/___/_____

Tell us about the reason for your visit today

What is the reason for your visit today?

When did this condition start (onset)?

Place of injury? ☐ Sports ☐ Home ☐ Auto Accident ☐ Workplace ☐ School ☐ Non-applicable

How often does the pain/numbness occur? ☐ Rare ☐ Intermittent ☐ Occasional ☐ Persistent

What is the status of your condition since the onset date? ☐ Unchanged ☐ Improving ☐ Fluctuating ☐ Stable ☐ Worse ☐ Resolved

What is the severity of your pain/numbness at its worst? (Circle a number) No Pain - 0 1 2 3 4 5 6 7 8 9 10 - Incapacitating

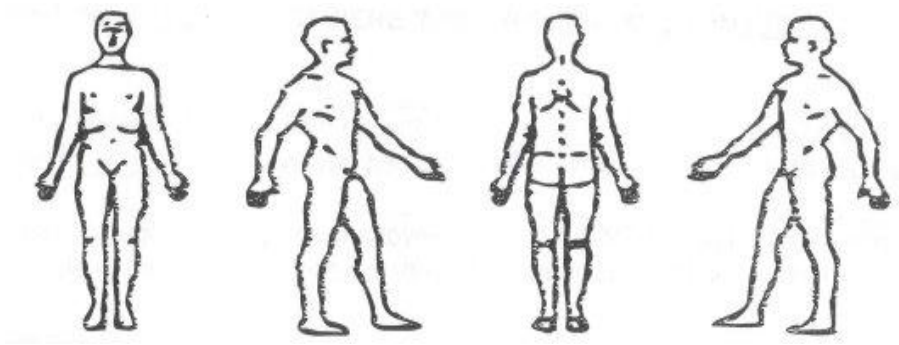
What type of pain/numbness are you experiencing? Check all that apply.

☐None ☐Ache ☐Burning ☐Deep ☐Superficial ☐Dull ☐Localized ☐Piercing
☐Sharp ☐Shooting ☐Stabbing ☐Throbbing ☐Discomfort ☐Electric ☐Tingling ☐Numb

What is the location of your pain/numbness? Check all that apply.

☐ Upper back ☐ Mid back ☐ Lower back ☐ Gluteal area ☐ Right flank ☐ Left flank ☐ Legs
☐ Thighs ☐ Neck ☐ Shoulder – (circle one) RT/LT/Both ☐ Arm – (circle one) RT/LT/Both ☐ Hand – (circle one) RT/LT/Both ☐ Fingers – (circle one) RT/LT/Both ☐ Other: _____

Location of Pain: *On the diagram below **"SHADE"** all areas where you feel pain and **"X" the areas that hurt the most***



Is your condition aggravated by? Check all that apply

☐ Nothing ☐ Daily activity ☐ Ascending stairs ☐ Descending stairs ☐ Coughing ☐ Driving
☐ Flexion ☐ Extension ☐ Lifting weight ☐ Bending ☐ Rotation/twisting ☐ Standing
☐ Sitting ☐ Walking ☐ Lying down/sleep ☐ Exercise ☐ Other:_____

Is your condition relieved by? Check all that apply

☐ Nothing ☐ Ice ☐ Heat ☐ Elevation ☐ Mobility ☐ Rest ☐ Stretching
☐ Exercise ☐ Brace ☐ Massage ☐ Physical therapy ☐ Injection ☐ Over the counter meds ☐ Pain medication

Tell us about any past medical treatment

☐Never been treated for condition	Start Date	☑ Receiving now	End Date	Name of facility where treatment was completed	% of relief 0-100
Activity modification	___/___/____	☐	___/___/____		
Bracing	___/___/____	☐	___/___/____		
Injection/nerve block	___/___/____	☐	___/___/____		
Drug/medication therapy	___/___/____	☐	___/___/____		
Physical therapy	___/___/____	☐	___/___/____		
Physician prescribed home exercise	___/___/____	☐	___/___/____		
Resting the area	___/___/____	☐	___/___/____		
TENS unit	___/___/____	☐	___/___/____		
Other: _____	___/___/____	☐	___/___/____		

COASTAL ORTHOPEDICS

Patient name: _____ Date of birth ___/___/_____ Today's date___/___/_____

Mark ONE number in each section that most closely describes you today

Section 1 – Pain Intensity

1) I have no pain at the moment
2) The pain is very mild at the moment
3) The pain is moderate at the moment
4) The pain is fairly severe at the moment
5) The pain is very severe at the moment
6) The pain is the worst imaginable at the moment

Section 2 – Personal Care

1) I can look after myself normally without causing extra pain
2) I can look after myself, but it is very painful
3) It is painful to look after myself and I am slow and careful
4) I need some help, but can manage most of my personal care
5) I need help every day in most aspects of self-care
6) I do not get dressed, I wash with difficulty and stay in bed

Section 3 – Lifting

1) I can lift heavy weights without causing extra pain
2) I can lift heavy weights, but it gives me extra pain
3) Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned (i.e. on table)
4) Pain prevents me from lifting heavy weights if they are conveniently positioned.
5) I can lift very light weights.
6) I cannot lift or carry anything at all.

Section 4 – Walking

1) Pain does not prevent me from walking any distance
2) Pain prevents me from walking more than 1 mile
3) Pain prevents me from walking more than ¼ mile
4) Pain prevents me from walking more than 100 yards
5) I can walk only using a cane or crutches
6) I am in bed most of the time and have to crawl to the toilet

Section 5 – Sitting

1) I can sit in any chair as long as I like
2) I can sit in my favorite chair as long as I like
3) Pain prevents me from sitting more than 1 hour
4) Pain prevents me from sitting more than ½ hour
5) Pain prevents me from sitting more than 10 minutes
6) Pain prevents me from sitting at all

Section 6 – Standing

1) I can stand as long as I want without extra pain
2) I can stand as long as I want, but it gives me extra pain
3) Pain prevents me from standing more than 1 hour
4) Pain prevents me from standing more than ½ hour
5) Pain prevents me from standing more than 10 minutes
6) Pain prevents me from standing at all

Section 7 – Sleeping

1) My sleep is never disturbed by pain
2) My sleep is occasionally disturbed by pain
3) Because of pain, I have less than 6 hours of sleep
4) Because of pain, I have less than 4 hours of sleep
5) Because of pain, I have less than 2 hours of sleep
6) Pain prevents me from sleeping at all

Section 8 – Sex Life (If Applicable)

1) My sex life is normal and causes no extra pain
2) My sex life is normal, but causes some extra pain
3) My sex life is nearly normal, but is very painful
4) My sex life is severely restricted by pain
5) My sex life is absent because of pain
6) Pain prevents any sex life at all

Section 9 – Social Life

1) My social life is normal and causes me no extra pain
2) My social life is normal but increases the degree of pain
3) Pain has no significant effect on my social life apart from limiting my more energetic interest (i.e. sports, etc.)
4) Pain has restricted my social life and I don't go out often
5) Pain has restricted my social life to home
6) I have no social life because of pain

Section 10 – Traveling

1) I can travel anywhere without extra pain
2) I can travel anywhere, but it gives me extra pain
3) Pain is bad, but I manage journeys over 2 hours
4) Pain restricts me to journeys of less than 1 hour
5) Pain restricts me to short journeys under 30 minutes
6) Pain prevents me from traveling except to receive treatment

To be completed by medical staff:

Reviewed By:_____ Date:_____ Total:_____