Patient Name ____________ SS # ____________ ID # ____________ Birthday ___ /___/___ Date___/___/___

Chief Complaint (Describe your medical problem) ____________

HPI

Where does it hurt? ____________

Describe the quality of pain: stabbing, aching, etc.

Rank severity of pain on scale of 1 = least pain to 10 = worst pain 1 2 3 4 5 6 7 8 9 10

How long does the pain last?

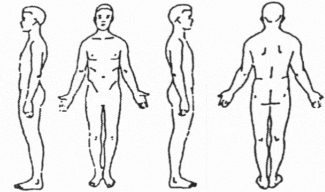
When is pain the worst: with activity? at night?

What activities worsen pain? ____________

What makes pain better or worse? ____________

Other symptoms ____________

Put an "X" where your pain is located. If you have numb places, please mark them with a dot (●).



ROS/PMH (Check Y=yes, N=no)

Y	N	Constitutional:
		fever
		chills
		night sweats
		weight loss
		Other:
Y	**N**	**Eyes:**
		glasses
		double vision
		blurring
		Other:
Y	**N**	**Ears, nose, mouth, throat:**
		hearing loss
		ringing
		dizziness
		hoarseness
		Other:
Y	**N**	**Cardiovascular:**
		heart attack
		arrhythmia
		pacemaker
		valve disease
		congestive heart disease
		chest pain or angina
		peripheral vascular disease
		blood clots in legs or DVT's
		Other:
Y	**N**	**Respiratory:**
		asthma
		bronchitis
		TB exposure
		emphysema
		pulmonary embolism
		Other:
Y	**N**	**GI:**
		ulcers
		gastritis
		Crohn's disease

Y	N	GI (cont.)
		ulcerative colitis
		gall stones
		abdominal pain
		diarrhea
		Other:
Y	**N**	**GU:**
		kidney failure
		kidney stones
		urinary infections
		incontinence
		abnormal menstrual bleeding
		Other:
Y	**N**	**Musculoskeletal:**
		osteoarthritis
		rheumatoid arthritis
		prior fractures
		swelling
		stiffness
		bursitis
		Other:
Y	**N**	**Skin or Breast:**
		new moles
		other new skin lesions
		rashes
		ulcers
		masses
		Other:
Y	**N**	**Neurological:**
		stroke
		seizure
		weakness
		memory loss
		incoordination
		speech difficulty
		numbness
		Other:

Y	N	Psychiatric:
		depression
		moodiness
		sleep disorder
		hallucinations
		Other:
Y	**N**	**Endocrine:**
		thyroid condition
		diabetes
		hypertension
		Other:
Y	**N**	**Heme / Lymph:**
		anemia
		benign tumors (describe)
		sickle cell disease
		cancer
		bleeding disorder
		AIDS / HIV
		swollen lymph nodes
		Other:

List all drug allergies:

List all medications:

PSH:

	Prior Operations (type)	Year	Surgeon
1.			
2.			
3.			
4.			

Chronic Problem List

Y	N	Social History:
		Occupation:
		Currently employed?
		Disability: If yes, since ____________
		Retired?
		Tobacco? If yes, # packs/day ________, # years ________
		Alcohol? If yes, how much? ____________
		Other Drugs? If yes, explain:

Y	N	Family History of:
		Cancer? If yes, who and what kind?
		diabetes
		rheumatoid arthritis
		heart disease
		hypertension
		sickle cell
		Other:

Family Physician:

Spinecare Medical Group

SMG FORM 103