SPINE INSTITUTE *of the Carolinas*

Jeffery M. Reuben, MD   K. Craig Boatright, MD

Past Medical History

A. Please list any medical issues past or present. Please include treatment and the medical doctor currently caring for each issue: *(use back of page if necessary)*

	Medical Issue	Treatment	Treating Physician
1			
2			
3			
4			
5			

B. Please List all past surgical procedures: *(use back of page if necessary)*

	Surgery	Year	Surgeon	Did symptoms resolve?
1				☐ Yes ☐ No
2				☐ Yes ☐ No
3				☐ Yes ☐ No
4				☐ Yes ☐ No
5				☐ Yes ☐ No

C. Please list any medications you are taking: *(use back of page if necessary)*

	Medication	Dose/Times per day	Taken for	Prescribing MD
1				
2				
3				
4				
5				
6				

D. Please list all injuries you can recall: *(use back of page if necessary)*

	Injury	Date	Comments
1			
2			
3			

E. Please list all medication and food allergies: *(use back of page if necessary)*

	Allergy	Type of reaction
1		
2		
3		
4		

    *Patient Name:*__________________________________

Social History

A. Do you currently smoke? ☐ No ☐ Yes How many packs/day?_____ How many years?_____

If you quit smoking, approximately how long ago did you quit?____________________

B. Do you drink alcohol? ☐ No ☐ Yes How many drinks/week?_____

C. What is your current marital status?____________________

List the people who live in your household including their relation to you and age:__________________

____

D. Highest level of education completed:

☐ High School ☐ College ☐ Graduate School ☐ Other ______________________________

Current or last occupation:____

What is your current work status?

☐ Full-time without restriction
☐ Part-time or light duty
☐ Unemployed
☐ Retired
☐ Unable to work

If unable to work, how long have you been unable to work and why:__________________________________
____
____
____

E. Please check all that apply:

1. Are your symptoms related to: ☐ **On the job injury** ☐ **Motor vehicle accident**
2. Have you applied for or received: ☐ **Workers Compensation** ☐ **Social Security Disability**
3. Have you required an attorney to assist you with your current medical situation? ☐ Yes ☐ No

Family History

A. Do any of the following illnesses run in your family? *(check all that apply)*

☐ Cancer ☐ Diabetes ☐ Heart Disease
☐ Scoliosis ☐ Ankylosing Spondylitis ☐ Rheumatoid Arthritis
☐ Other ____

B.

	Living	Deceased	Current age or age at death	Serious illnesses and/or Cause of death (if applicable)
Mother	☐	☐		
Father	☐	☐		

C. Has anyone in your family had difficulty with anesthesia? ☐ No ☐ Yes

If yes, please explain:____

SPINE INSTITUTE of the Carolinas

Jeffery M. Reuben, MD   K. Craig Boatright, MD

Review of Systems

A. Please check (√) the line beside each condition or diagnosis as it applies to you:

Now	Past	Condition
☐	☐	Recent weight loss ______
☐	☐	Persistent fevers or chills ______
☐	☐	Diagnosis of cancer ______
☐	☐	Visual disturbances such as spots or double vision ______
☐	☐	Hoarseness ______
☐	☐	Difficulty swallowing ______
☐	☐	Toothache or abscess ______
☐	☐	Peripheral vascular disease or hardening of the arteries ______
☐	☐	Chest pain or angina ______
☐	☐	Heart attack or heart disease ______
☐	☐	Congestive heart failure (CHF) ______
☐	☐	Abnormal heart beat ______
☐	☐	Shortness of breath ______
☐	☐	Asthma or bronchitis ______
☐	☐	COPD or lung disease ______
☐	☐	Use of supplemental oxygen day or night ______
☐	☐	Tuberculosis (TB) or positive PPD ______
☐	☐	Stomach discomfort with medicine ______
☐	☐	Ulcer ______
☐	☐	Hepatitis ______
☐	☐	Loss of control of urine or stool ______
☐	☐	Difficulty starting urination ______
☐	☐	Burning with urination ______
☐	☐	Rashes ______
☐	☐	Areas of non healing sores ______
☐	☐	Frequent headaches or migraines ______
☐	☐	Peripheral neuropathy ______
☐	☐	Stroke ______
☐	☐	Seizures ______
☐	☐	Depression or other psychiatric illness ______
☐	☐	Diabetes or blood sugar control issues ______
☐	☐	Bleeding problems or blood clots ______
☐	☐	Anemia ______
☐	☐	Latex allergy ______
☐	☐	Shellfish or iodine allergy ______
☐	☐	Contrast allergy ______

B. Do you have any other joint, bone or muscle problems for which you see a health care provider?

☐ No ☐ Yes If yes, please explain ______

______

______

PMSFH and ROS reviewed with patient during clinical encounter   date

Visual Analog Pain Scale (VAS)

Mark the areas on your body where you feel the described sensations using the appropriate symbols from the table below:

Numbness	Pins & Needles	Burning	Stabbing	Aching
= = = = = =	o o o o o o o o	x x x x x	/ / / / / /	Δ Δ Δ

Indicate your pain level by placing a line inside the charts below with a "0" for no pain and a "10" for the worst imaginable pain:

Pain at its worst: 0 5 10

Pain at its best: 0 5 10

Patient Name: ____________________ **Date:** __________