

# SUNSHINE SPINE & PAIN, P.A.

Patient name \_\_\_\_\_

Date \_\_\_\_\_

**Social history:**            **Right Handed ( )    Left Handed ( )**

Alcohol: ( ) None            ( ) Daily            ( ) Few per week            ( ) 1 per week    ( ) few per month    ( ) rare  
Drug Use: ( ) None            ( ) Other \_\_\_\_\_            Ever been in drug/Alcohol Treatment ( ) Yes ( ) No  
Smoker ( ) yes ( ) # packs daily \_\_\_\_\_ how many years \_\_\_\_\_ when stopped \_\_\_\_\_

\*\*\*\*\*We strongly recommended smoking cessation

## **Family History:**

Mother ( ) Alive            ( ) Deceased... Age \_\_\_\_\_ Cause/medical conditions \_\_\_\_\_  
Father ( ) Alive            ( ) Deceased....Age \_\_\_\_\_ Cause/medical conditions \_\_\_\_\_  
Family Medical Problems ( ) Diabetes            ( ) Heart Disease            ( ) Cancer \_\_\_\_\_ ( ) Other \_\_\_\_\_

## **Review of Systems:**

Possibly Pregnant: ( ) Yes ( ) No

( ) None            **General**            ( ) numbness/tingling yes/ no WHERE? \_\_\_\_\_ **OLD/NEW**

( ) new incontinence (urine / stool)            ( ) Coordination/ Off Balance

( ) None            **Constitutional**    ( ) fever            ( ) weight loss            ( ) tiredness

( ) None            **Eyes**            ( ) blurred vision            ( ) Haloes around lights            ( ) double vision

( ) None            **Ear Nose Throat** ( ) deafness            ( ) ringing            ( ) dizziness            ( ) vertigo

( ) None            **Heart**            ( ) chest pain            ( ) irregular heart beat            ( ) pounding in chest

( ) None            **Lungs**            ( ) shortness of breath            ( ) wheezing            ( ) cough

( ) None            **Abdomen**            ( ) diarrhea            ( ) constipation            ( ) black stools ( ) heartburn            ( ) Stomach bleeding

( ) None            **Urinary**            ( ) burning            ( ) loss of urine            ( ) kidney disease

( ) None            **Menstrual**            ( ) regular            ( ) irregular            ( ) severe pain            ( ) post menopausal

( ) None            **Musculoskeletal** ( ) sprains            ( ) swelling            ( ) stiffness

( ) None            **Skin/Breast**            ( ) rash            ( ) sores            ( ) masses

( ) None            **Neurologic**            ( ) balance problems ( ) memory problems            ( ) falls

( ) None            **Behavioral**            ( ) depression            ( ) anxiety            ( ) sleep disturbance

( ) None            **Endocrine**            ( ) sleep all time            ( ) hyperactive            ( ) too hot            ( ) too cold

( ) None            **Blood/lymphatic** ( ) easy bruising            ( ) bleeding problems            ( ) anemia

( ) None            **Immunologic**            ( ) itching            ( ) frequent colds/infections

# SUNSHINE SPINE & PAIN, P.A.

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ #  
Family Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

## Occupation:

**Do you have trouble getting numb at the dentist:** ( ) yes ( ) No

**Past Medical History:** Check here if all are negative ( )

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> High blood pressure    | <input type="checkbox"/> Hepatitis/liver disease | <input type="checkbox"/> Phlebitis/ blood clots    |
| <input type="checkbox"/> Heart disease          | <input type="checkbox"/> Kidney Problems/ Stones | <input type="checkbox"/> Stomach Ulcer disease     |
| <input type="checkbox"/> Heart attack           | <input type="checkbox"/> Thyroid disease         | <input type="checkbox"/> Bleeding disorder         |
| <input type="checkbox"/> Irregular heart rhythm | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Asthma                    |
| <input type="checkbox"/> Stroke                 | <input type="checkbox"/> Osteoporosis            | <input type="checkbox"/> Emphysema/ COPD           |
| <input type="checkbox"/> Seizures               | <input type="checkbox"/> Rheumatoid Arthritis    | <input type="checkbox"/> Cancer ( What kind) _____ |
| <input type="checkbox"/> Glaucoma               | <input type="checkbox"/> Depression _____        | <b>Trauma:</b> _____                               |
| <input type="checkbox"/> Fibromyalgia           | <input type="checkbox"/> Other _____             | <input type="checkbox"/> Other _____               |

**Surgical History:** Check here if none ( )

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Low Back Surgery (when) _____    | <input type="checkbox"/> Where _____          | <input type="checkbox"/> Surgeon _____ |
| <input type="checkbox"/> Neck Surgery (when) _____        | <input type="checkbox"/> Where _____          | <input type="checkbox"/> Surgeon _____ |
| <input type="checkbox"/> Heart surgery ( year) _____      | <input type="checkbox"/> Cancer surgery _____ |  |
| <input type="checkbox"/> Joint replacement ( which) _____ |   |  |
| <input type="checkbox"/> Appendix                         | <input type="checkbox"/> Hernia               | <input type="checkbox"/> Galbladder    |
| <input type="checkbox"/> Hysterectomy                     | <input type="checkbox"/> OTHER SURGERY _____  |  |

## Allergies:

- |                                      |                                    |                                       |                                  |                                |  |
|--------------------------------------|------------------------------------|---------------------------------------|----------------------------------|--------------------------------|--|
| Foods _____                          | <input type="checkbox"/> Shellfish | <input type="checkbox"/> Iodine       | <input type="checkbox"/> I V Dye | <input type="checkbox"/> Latex | <input type="checkbox"/> Adhesive Tape |
| <input type="checkbox"/> Pennicillin | <input type="checkbox"/> Sulfa     | <input type="checkbox"/> Others _____ |                                  |                                |  |

## Current Medications:

Name of drug	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Pain in the lower back/ neck:** 0 1 2 3 4 5 6 7 8 9 10

**Pain in the arm/ leg:** 0 1 2 3 4 5 6 7 8 9 10

Pls draw/ color painful area



