

# Spine and Orthopedic Center

Michael Price, MD  
Patient Medical History

Patient's Name:		Date of Birth:	Age:	Sex: ( ) M ( ) F
Primary Care Physician:		Referred By:		Job Title:
Reason for today's visit:				
Date Condition Began:		Indicate nature and location of problem:		
Describe your symptoms:			Any history of trauma?	
What makes your symptoms better?			What makes your symptoms worse?	
<p>Mark the diagram to indicate location of pain:</p> <div style="display: flex; justify-content: space-around; margin-bottom: 10px;"> <span>RIGHT</span> <span>LEFT</span> </div>				<p>Indicate your pain severity: <b>PAIN SCALE</b> (circle)</p> <p style="text-align: center;">1</p> <p style="text-align: center;">2</p> <p style="text-align: center;">3</p> <p style="text-align: center;">4</p> <p style="text-align: center;">5</p> <p style="text-align: center;">6</p> <p style="text-align: center;">7</p> <p style="text-align: center;">8</p> <p style="text-align: center;">9</p> <p style="text-align: center;">10</p>

Patient's Name:

Date of Service:

Please list all the medical problems:


Please list all the surgeries that you had:


Please list all the current medications:


List any drug ALLERGIES:


Social History:

Family History of any related medical problems:


Review of Systems: (Circle if positive)

<b>GENERAL:</b>	Weight change	Dizziness	Fatigue	Sleeping difficulty	Fever
<b>SKIN:</b>	Rash	Lesions			
<b>HEADACHE:</b>	Decrease hearing	Decrease vision	Nasal discharge		
<b>NECK:</b>	Pain spasm	Difficulty swallowing			
<b>BLOOD;</b>	Bleeding (if yes specify site)				
<b>LUNGS:</b>	Shortness of Breath	Cough	Vomiting		
<b>HEART:</b>	Chest Pain	Palpitations			
<b>ABDOMEN:</b>	Abdominal Pain	Nausea	Vomiting		
<b>KIDNEY:</b>	Pain on urination	Blood in the urine			
<b>ENDO:</b>	Heat intolerance	Cold intolerance			
<b>NEURO:</b>	Numbness	Tingling	Weakness		
<b>BACK</b>	Pain	Spasm			
<b>OTHER:</b>	Anxiety	Depression			