SPINAL DIAGNOSTICS

Robert D. Heros, M.D. | Jason G. Anderson, D.O. | Omar Halawa, M.D.
Heather L. Marsh, PA-C | Lindsay A. Purtell, PA-C

HEALTH HISTORY

Patient Name: _____ Date of Birth:_____

Who referred you to us?_____

Occupation: _____ Primary Care Provider: _____

Is this a: [ ] Workman's Comp Claim *or* [ ] Motor Vehicle Accident Do you have a lawyer for this injury? [ ] Yes [ ] No

Is English your primary language? [ ] Yes [ ] No If no, which language? _____

IN THE PAST 2 WEEKS, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? *(Check all that apply)*

☐ Fever	☐ Chills	☐ Night Sweats	☐ Insomnia
☐ Involuntary Weight Loss	☐ Headache	☐ Sore Throat	☐ Visual Difficulty
☐ Ringing In Ear	☐ Seizures/Tremors	☐ Sinus Congestion	☐ Chest Pain
☐ Palpitations	☐ Wheeze/Cough	☐ Nausea/Vomiting	☐ Stomach Pain
☐ Diarrhea	☐ Rash	☐ Blood In Urine/Stool	☐ Easy Bruising
☐ Joint Pain/Swelling	☐ Swelling	☐ Excessive Thirst/Appetite	☐ Fainting
☐ Recent Bleeding	☐ Shortness of Breath	☐ Loss of Bowel/Bladder Control	☐ Hearing Loss

PAIN HISTORY

Date of onset of present pain (date of injury or accident): _____

CAUSE OF PAIN:

☐ Motor Vehicle Accident	☐ Accident at Work	☐ Accident Away from Work	☐ Sports
☐ Unknown Cause	☐ Other:		

PAIN LOCATION:

☐ Left Side	☐ Right Side	☐ Both Sides		
☐ Headache	☐ Neck	☐ Shoulder	☐ Leg/Foot	☐ Arm/Hand
☐ Chest	☐ Upper Back	☐ Mid Back	☐ Abdomen	☐ Low Back
☐ Buttock	☐ Other:			

PAIN QUALITY:

☐ Burning	☐ Throbbing	☐ Aching	☐ Stabbing	☐ Numbness
☐ Tingling	☐ Weakness	☐ Shooting	☐ Dull	☐ Sharp
☐ Other:				

PAIN DURATION:

☐ Occasional	☐ Off and On	☐ Quick/Shooting	☐ Frequent	☐ Daily	☐ Constant

ACTIVITIES THAT MAKE PAIN WORSE:

☐ Sitting	☐ Standing	☐ Walking	☐ Bending Forward
☐ Arching Backwards	☐ Rotational Movement	☐ Driving	☐ Rest/Sleep

TIMES OF PAIN:

☐ In The Morning	☐ In The Evening	☐ With Certain Movements	☐ During Rest	☐ During of After Activity

ACTIVITIES THAT MAKE PAIN BETTER:

☐ Sitting	☐ Standing	☐ Walking	☐ Movement
☐ Lying Down	☐ Leaning Forward	☐ Leaning Back	☐ Heat
☐ Ice	☐ Rest	☐ Other:	

6464 SW Borland Rd., Suite A-2 Tualatin OR 97062
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Patient Name: _____ Date of Birth: _____

Height: _____ Weight : _____

DO YOU HAVE A SIGNIFICANT HISTORY OR CURRENTLY HAVE:

Y	N	NEURO	
		Seizures	Last:
		Stroke/TIA	Date:
		Glaucoma	
		Numbness/Weakness/Paralysis	
		Bell's Palsy/Parkinson's	

Neurologist:

Opthamologist:

Y	N	CARDIOVASCULAR	
		Heart Attack (MI)	Date:
		Chest Pain (Angina)	
		Irregular Heart Rate/Rhythm/Pacemaker	
		High Blood Pressure	
		Bleeding Disorder: (specify)	
		Anticoagulant Treatment	

Cardiologist:

Anticoagulant Management:

Y	N	RESPIRATORY
		Shortness of Breath
		Asthma or Wheezing/Inhaler
		Snoring/Sleep Apnea/Difficult Airway
		Emphysema/COPD
		Chronic/Frequent Bronchitis or Pneumonia
		Tuberculosis (TB)

Pulmonologist:

Y	N	LIFESTYLE		
		Do you smoke?	# years smoked:	# packs per day:
		Former Smoker, year you quit?		
		Do you drink alcohol?		Drinks/week:
		Treated for drug/alcohol dependency?		
		Currently pregnant?		
		Date of your last period:		
		[ ] Menopause [ ] Hysterectomy		

Y	N	SKIN
		Open Wounds/Breaks in Skin
		Rashes
		History of Cold Sores/Shingles/Herpes

Dermatologist:

Y	N	GASTROINTESTINAL/GENITOURINARY
		Heartburn/GERD/Reflux/Hiatal Hernia
		Kidney Disease: (specify)
		Hepatitis/Liver Function
		Colitis/Other Abdominal Problems

Gastroenterologist:

Nephrologist:

Y	N	ENDOCRINE/IMMUNE SYSTEM	
		Diabetic: [ ] Type 1 [ ] Type 2	Avg AM level:
		Thyroid Problems	
		HIV/AIDS	

Endocrinologist:

Y	N	MUSCLE/SKELETAL
		Osteoporosis
		Use of a Cane/ Wheelchair/Walker

Y	N	OTHER	
		MRSA Infection	Date:
		Cancer/Chemo: (specify)	

Oncologist:

		Serious problems with any prior anesthetics
		Family history with serious anesthesia problems
		Infection/Illness in past 6 months:
		Current, or Date Resolved:

Other medical problems or comments:

Please list any previous surgeries and year of surgery:

When was your last vaccination/flu shot?

OFFICE USE ONLY

Patient Initials: ____ Date: _____ Patient Initials: ____ Date: _____

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Patient Name: _____ Date of Birth: _____

PREVIOUS TREATMENTS FOR THIS PAIN

PHYSICAL THERAPY

☐ Never Tried ☐ Not Helpful ☐ Minimally Helpful ☐ Somewhat Helpful ☐ Helpful

Where?_____ How long/Last Treatment: _____

CHIROPRACTIC CARE

☐ Never Tried ☐ Not Helpful ☐ Minimally Helpful ☐ Somewhat Helpful ☐ Helpful

MASSAGE

☐ Never Tried ☐ Not Helpful ☐ Minimally Helpful ☐ Somewhat Helpful ☐ Helpful

ACUPUNCTURE

☐ Never Tried ☐ Not Helpful ☐ Minimally Helpful ☐ Somewhat Helpful ☐ Helpful

SPINE INJECTIONS

☐ Never Tried ☐ Not Helpful ☐ Minimally Helpful ☐ Somewhat Helpful ☐ Helpful

SPINE SURGERY

☐ Never Tried ☐ Not Helpful ☐ Minimally Helpful ☐ Somewhat Helpful ☐ Helpful

MEDICATIONS/OTC PAIN MEDS

☐ Never Tried ☐ Not Helpful ☐ Minimally Helpful ☐ Somewhat Helpful ☐ Helpful

DIAGNOSTIC IMAGING

MRI Where:_____ Approx Date: _____

CT Where:_____ Approx Date: _____

XRAY Where:_____ Approx Date: _____

MEDICATIONS

MEDICATION NAME Please list all current prescription and over-the counter medications.

PREVIOUS SURGERIES

SURGERY	YEAR

Preferred Pharmacy: _____ City: _____ Phone: _____

ALLERGIES:

Please list ALL medication allergies

☐ No known drug allergies ☐ Tape/Adhesives ☐ Latex ☐ Iodine/Contrast Dye ☐ Shellfish

Substance	**Reaction**(Itching, rash, breathing difficulties, etc.)

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