

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 _____ | Trauma: _____ |
| <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"/> Pennicillin | <input type="checkbox"/> Iodine | <input type="checkbox"/> IV Dye | <input type="checkbox"/> Latex | <input type="checkbox"/> Adhesive Tape |
| <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



