CHICAGO NEUROSPINE SURGERY PLLC

Medical History Form

Date: **Age:**
Height:
Name: **Weight:**

Referring Doctor:

Please describe your symptoms:

When did your symptoms start?

Are your symptoms (circle one): constant, periodic

Have you had similar symptoms previously?

Pain worst in: Sitting, standing, lying down

Pain better with: Sitting, standing, lying down

What else makes the pain worse?

What else makes the pain better?

Past Medical History
1.
2.
3.
Past surgical History
1.
2.
3.
Allergies:

Medications:

Social History
Smoking: none or …..packs x …..years
Living with: spouse, self, parents, kids

Family History (live, dead, include medical problems)
1. Father:
2. Mother::
3. Siblings:

Review of system (circle all that applies):

General: fever, chills, weight loss, weight gain
Muscle/Joints: pain, weakness, decreased ROM
Neurological: Weakness, numbness, tingling
Urologic: urinary incontinence,difficulty voiding
Psychiatric: depression, anxiety

Work: Working(fill the rest) or Retired

Are you currently working:

Place of employment:

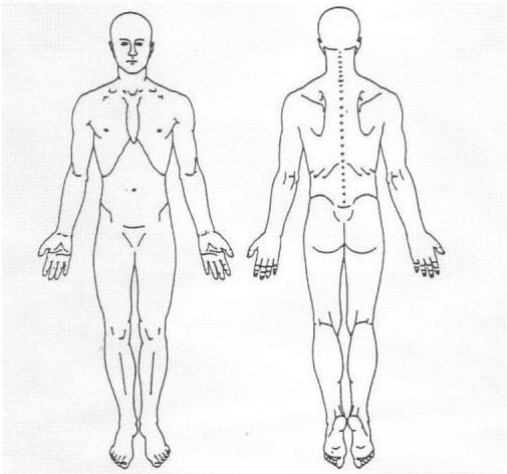
Job Description:

Circle which applies:
Heavy duty (50-100 lbs)
Medium duty (20-50 lbs)
Light duty (up to 20 lbs)
Desk work (less than 10 lbs)

Prior Treatments (circle all applies)

-Bed Rest (No relief, some relief, good relief)
-Physical therapy (No relief, some relief, good relief)
-Chiropractic (No relief, some relief, good relief)
-Cortisone injection (No relief, some relief, good relief)
-Brace (No relief, some relief, good relief)

Shade the affected area with pain



Pain Severity (circle one): 0 1 2 3 4 5 6 7 8 9 10