



Past Medical History

Patient Name _____ DOB _____ Date _____

Do you have or have you had:

- High Blood Pressure
 Diabetes
 Stroke
 Cancer
 Epilepsy/Seizure
 Heart Problems
 Depression or Psychiatric Disease
 Thyroid Problems
 None of these

Have you done physical therapy for the issue you are seeing the doctor for? Yes No
 If yes, indicate how many sessions/how long and name of therapist: _____

Past Surgical History

Previous Spine Surgery? Yes No If yes, please indicate type and year _____

Other Previous Surgeries (indicate type and year): _____

Allergies

Do you have any allergies? Yes No If yes, please describe _____

Medications

List medications you are currently taking

Medication Name	Dose/Frequency
_____	_____
_____	_____
_____	_____

Social History

Do you smoke? Yes No If yes, how many cigarettes do you smoke per day? _____

Yes No If yes, are you interested in quitting?

Do you drink alcohol? Yes No If yes, how often? _____ How many drinks? _____

Family History

	Living (Age)	Health Status	Deceased (Age)	Cause of Death
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____

	Number	Age(s)	Serious Illness	Number Deceased	Age at Death
Brother(s)	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____
Child(ren)	_____	_____	_____	_____	_____

Work History

Occupation: _____

Are you still working? Yes No

If no, what is the date you last worked? _____