SBI
THE SPINE & BRAIN
INSTITUTE

Medical History .

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Patient Name: _____ Date of Birth: _____

Age: _____ Height: _____ Weight: _____

Staff Only BP:

Primary Care Physician: _____ Referring Physician: _____

Reason for visit (symptoms/problems): _____

How long have you had symptoms? _____

Is your current problem a result of an accident/injury? ☐ Yes ☐ No If yes, date of accident/injury _____

Type of accident: ☐ Work Related ☐ Auto ☐ Other: _____

Past Medical Problems

Any major illnesses and/or injuries?

Hypertension	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Blood Clotting	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Recent Infections	☐ Y es	☐ No	Other: _____					

Medications

Current Medications (including over the counter medications)	Dose	Frequency

Allergies to Medications: _____

_____

Surgeries/Hospitalizations

List previous surgeries and hospitalizations	Year	Complications

Have you ever had problems with anesthesia? ☐ Yes ☐ No Problem(s): _____

Family History

Family Members	Alive/Deceased	Age	Health Status/Cause of death
Grandmother (Mother's)			
Grandfather (Mother's)			
Grandmother (Father's)			
Grandfather (Father's)			
Mother			
Father			
Sister/Brother			
Sister/Brother			

Social History

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have any children? ☐ Yes ☐ No If yes, how many? _____

Do you live alone? ☐ Yes ☐ No If no, who lives with you? _____

Do you smoke? ☐ No, I have never smoked. ☐ Yes, I smoke _____ packs of cigarettes per day for _____ years.

☐ No, I quit _____ years ago. At the time, I smoked _____ packs of cigarettes per day for _____ years.

Do you drink alcohol? ☐ No ☐ No, but I used to ☐ Yes If yes, please answer questions below

How often did you have a drink containing alcohol in the past year?

☐ Never ☐ Once per month ☐ Two times per month ☐ Three times per moth ☐ Four or more times per week

How many drinks did you have on a typical day when you were drinking in the past year?

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

How often did you have six or more drinks on one occasion in the past year?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Are you at risk for AIDS (e.g., previous blood transfusion, drug abuse)? ☐ Yes ☐ No

If yes, please explain: _____

Spine problems

Have you had a trial of anti-inflammatory or muscle relaxants? ☐ Yes ☐ No

If yes, what type? _____ How long? _____

Have you had physical therapy? ☐ Yes ☐ No If yes, how long? _____

Have you had pain injections (e.g. epidural, facet or nerve block)? ☐ Yes ☐ No

If yes, when? _____ How many? _____

Which physician performed blocks? _____

Imaging

Do you have any implanted metal objects in your body? ☐ Yes ☐ No

Where? _____ When? _____

Do you have any vascular grafts? ☐ Yes ☐ No

Where? _____ When? _____

Do you have a pacemaker? ☐ Yes ☐ No

Are you claustrophobic? ☐ Yes ☐ No Do you wish to be pre-medicated (sedated) for MRI scans? ☐ Yes ☐ No

Review of Systems

Have you ever had or are you currently having problems with any of the following?

Constitutional:

Fever	☐ Yes	☐ No	
Weight Loss	☐ Yes	☐ No	
Excessive Fatigue	☐ Yes	☐ No	
Night sweats	☐ Yes	☐ No	

Eyes:

Do you wear glasses?	☐ Yes	☐ No	If yes, when was your last exam? _____
Infections	☐ Yes	☐ No	
Injuries	☐ Yes	☐ No	
Glaucoma	☐ Yes	☐ No	
Cataracts	☐ Yes	☐ No	

Ear, Nose, Throat and Mouth:

Hearing Loss	☐ Yes	☐ No	If you wear hearing aids, when was your last exam? _____
Ear Pain	☐ Yes	☐ No	
Ear Infections	☐ Yes	☐ No	
Ringing in Ears	☐ Yes	☐ No	If yes, ☐ Left ☐ Right ☐ Both
Balance Disturbance (e.g. Vertigo, Spinning)	☐ Yes	☐ No	
Nosebleeds	☐ Yes	☐ No	
Nasal Congestion	☐ Yes	☐ No	
Nasal Drainage	☐ Yes	☐ No	
Inability to Smell	☐ Yes	☐ No	
Sinus Problems	☐ Yes	☐ No	
Sinus Headache	☐ Yes	☐ No	
Sore Throats	☐ Yes	☐ No	
Mouth Sores	☐ Yes	☐ No	

Cardiovascular:

Chest Pain/Angina	☐ Yes	☐ No	If yes, when was your last EKG? _____
High Blood Pressure	☐ Yes	☐ No	
Irregular Pulse	☐ Yes	☐ No	
Heart Murmur	☐ Yes	☐ No	
High Cholesterol	☐ Yes	☐ No	
Swelling in Feet/Hands	☐ Yes	☐ No	
Leg Pain while walking	☐ Yes	☐ No	

Respiratory:

Asthma	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Lung Cancer	☐ Yes	☐ No
Bloody Sputum	☐ Yes	☐ No

When was your last Chest x-ray? _____

Review of Systems (cont.)

Have you ever had or are you currently having problems with any of the following?

Gastrointestinal:

Indigestion/Pain Eating	☐ Yes	☐ No
Nausea	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Blood in Vomit	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Abdominal Pain	☐ Yes	☐ No
Change in Bowel	☐ Yes	☐ No
Ulcers or Gastritis	☐ Yes	☐ No
Colon Cancer	☐ Yes	☐ No

Genitourinary:

Urinary Tract Infection	☐ Yes	☐ No
Painful Urination	☐ Yes	☐ No
Blood in Urine	☐ Yes	☐ No
Difficulty/Incontinence	☐ Yes	☐ No
Kidney Stones	☐ Yes	☐ No
Prostate Cancer (male)	☐ Yes	☐ No
Endometriosis (female)	☐ Yes	☐ No
Uterine/Cervical Cancer	☐ Yes	☐ No

Musculoskeletal:

Arm/Leg Weakness	☐ Yes	☐ No
Back Pain	☐ Yes	☐ No
Arm/Leg Pain	☐ Yes	☐ No
Joint Pain or Swelling	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No

Please list any broken bones _____

Integumentary:

Skin Disease	☐ Yes	☐ No
Skin Cancer	☐ Yes	☐ No
Breast Pain/swelling	☐ Yes	☐ No
Nipple Discharge	☐ Yes	☐ No

When was your last mammogram? _____

Neurological:

Fainting/Black Outs	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Memory Problems	☐ Yes	☐ No
Disorientation	☐ Yes	☐ No
Trouble with Speech	☐ Yes	☐ No
Inability to Concentrate	☐ Yes	☐ No
Double/Blurred Vision	☐ Yes	☐ No
Facial Weakness	☐ Yes	☐ No
Coordination problems in arms/legs	☐ Yes	☐ No

Psychiatric:

Anxiety	☐ Yes	☐ No	
Depression	☐ Yes	☐ No	
Other Psychiatric Disorder	☐ Yes	☐ No	If yes, please list _____

Review of Systems (cont.)

Have you ever had or are you currently having problems with any of the following?

Endocrine:

Diabetes	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Increase in Appetite	☐ Yes	☐ No
Hormone Problems	☐ Yes	☐ No
Excessive Thirst or Urination	☐ Yes	☐ No

Hematologic/Lymphatic:

Anemia	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Bleeding Tendencies	☐ Yes	☐ No
Swollen Glands or Lymph Nodes	☐ Yes	☐ No

Allergic/Immunologic:

Food Allergies	☐ Yes	☐ No
Nasal/Inhalant Allergy	☐ Yes	☐ No
Immunologic Disorder	☐ Yes	☐ No

The above information is accurate to the best of my knowledge.

Patient's Signature: _____ **Date:** _____