



**Intermountain Spine Institute**

5770 South 250 East  
Suite 135  
Salt Lake City, UT 84107

**Welcome**

Patient Medical History

Please answer all sections as completely as possible

Name \_\_\_\_\_

Age \_\_\_\_\_

Date \_\_\_\_\_

1. **Pain Drawing** - Using the symbols below, please mark the areas on your body where you feel the sensations depicted by the symbols.

Aching  
>>>

Numbness  
===

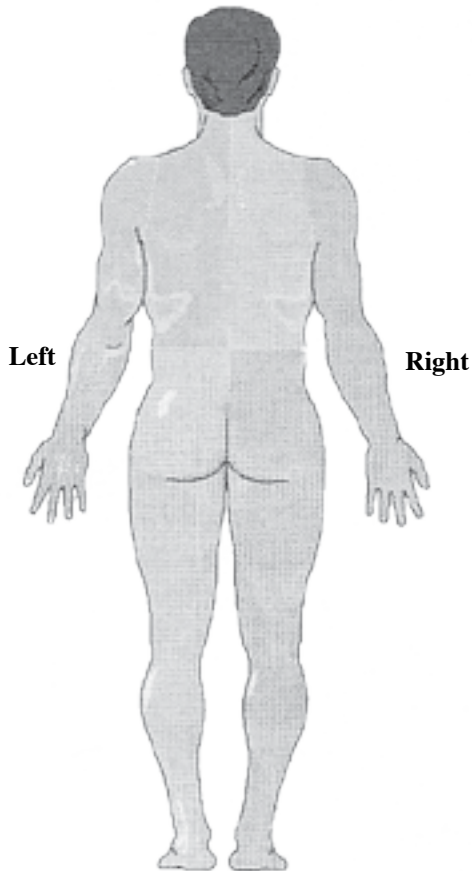
Pins & Needles  
OOO

Burning  
xxx

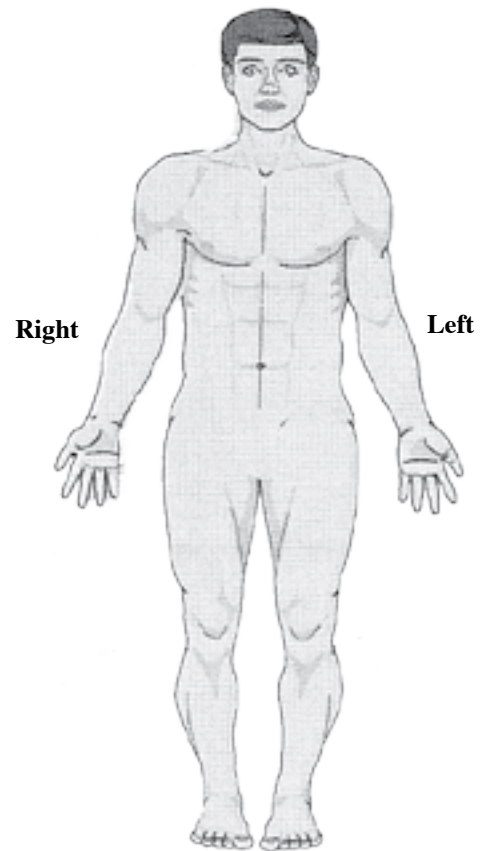
Stabbing  
///

Other  
□□□

BACK



FRONT



Please rate your current overall pain level by marking the scale below ( 0 = No Pain to 10 = Extremely Intense Pain):



2. Date of onset of pain \_\_\_\_\_ Work related?  Auto accident?

3. Please describe your problem.

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5. What activities make the pain worse:

Exercise  Sitting  Standing  Walking  Lying down

Bending forward  Bending backward  Other(s) \_\_\_\_\_

6. What activities reduce the pain:

Exercise  Sitting  Standing  Walking  Lying down

Bending forward  Bending backward  Other(s) \_\_\_\_\_

7. Please list medications you are currently taking or attach list: List attached

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8. Please list any allergies and/or side effects to medication:

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9. Please indicate if you have had any of the following studies:

Study	Date Performed	Where Performed	Study Results
Regular X-Rays			
MRI Scan			
CT Scan			
Bone Scan			
EMG			
Discogram			

10. Please list (in order) your surgical history:

Date of Surgery	Operation	Performed by Whom	Where Performed

11. Have you had any of the following treatments for your current problem? Check all that apply:

Physical Therapy                       Chiropractic                       Steroid injections

12. I have never smoked  I do smoke  I stopped in \_\_\_\_\_  \_\_\_\_\_ packs per day for \_\_\_\_\_ years.

13. I do not drink alcohol  I do drink alcohol  \_\_\_\_\_ drinks or beers per week.

14. Please check below any of the conditions you now have, or have had in the past 6 months:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Heart Attack/Heart Disease   | <input type="checkbox"/> Joint Pain             | <input type="checkbox"/> Loss of bladder control |
| <input type="checkbox"/> High Blood Pressure          | <input type="checkbox"/> Joint Stiffness        | <input type="checkbox"/> Loss of stool control   |
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Joint Redness/Swelling |  |
| <input type="checkbox"/> Clotting Problems            | <input type="checkbox"/> Infection              |  |
| <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Wheezing               |  |
| <input type="checkbox"/> Angina/Chest Pain            | <input type="checkbox"/> Pneumonia              |  |
| <input type="checkbox"/> Arthritis                    | <input type="checkbox"/> Recurring Cough        |  |
| <input type="checkbox"/> Neurological Disorder        | <input type="checkbox"/> Tuberculosis           |  |
| <input type="checkbox"/> Sleep Apnea                  | <input type="checkbox"/> Difficulty Swallowing  |  |
| <input type="checkbox"/> Stomach Ulcer/Gastric Reflux |   |  |

15. If any blood relatives have had any of these diseases, please check the disease, and indicate their relationship to you:

Disease	Relationship(s)
<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Back Pain	_____
<input type="checkbox"/> Neck Pain	_____
<input type="checkbox"/> Migraine Headaches	_____
<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Diabetes	_____

16. Please list below any other medical providers you have seen for your present problem:

Provider's Name/Title	Treatment

17. Please list below medical providers you have seen for previous back or neck problems:

Provider's Name/Title	Treatment

18. Are you currently employed? Yes  No  If no, date of last employment \_\_\_\_\_

Work Status (check one): Regular Duty  Light Duty  Not working

Occupation \_\_\_\_\_

19. Please note your physical work requirements (check one):

Heavy  Moderate  Light  Sedentary

20. Is an attorney helping you in respect to your condition/injury? Yes  No

21. Have you been pleased with previous medical treatment you have received for your problem? Yes  No

22. Please list any limitations to your normal activities you are currently experiencing:  
\_\_\_\_\_

23. What do you wish to accomplish at today's visit?  
\_\_\_\_\_

I attest that the information noted above accurately represents my symptoms and medical history.

\_\_\_\_\_  
Your signature

Pre-Op Use Only			
Height: _____	Weight: _____	Notes: _____	_____
BP: _____	Pulse: _____	Temp: _____	_____
Lungs: Clear	Rales		_____
Heart: NSR	Irregular		_____
			_____