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

Welcome

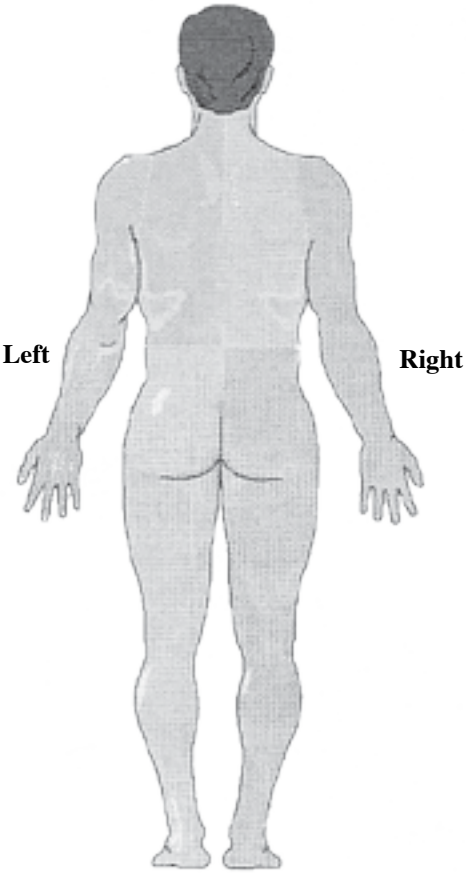
Patient Medical History
Please answer all sections as completely as possible

Name Age Date

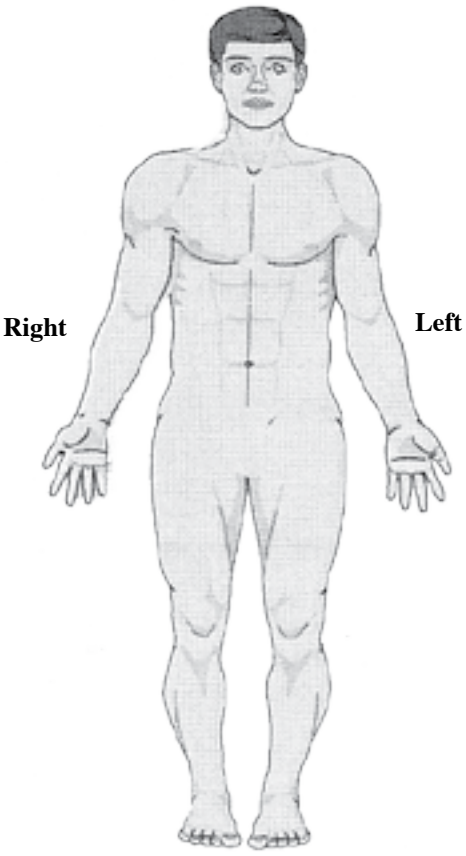
1. **Pain Drawing** - Using the symbols below, please mark the areas on your body where you feel the sensations depicted by the symbols.

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
> > >	= = =	O O O	x x x	/ / /	□□□

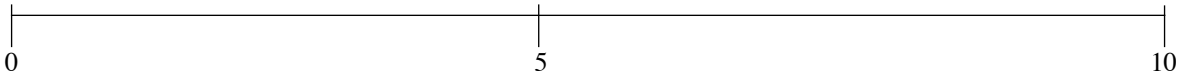
BACK



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.

_____

_____

_____

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 ☐

_____

_____

_____

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

_____

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:

- ☐ **Heart Attack/Heart Disease**
- ☐ **High Blood Pressure**
- ☐ **Diabetes**
- ☐ **Clotting Problems**
- ☐ **Cancer**
- ☐ **Angina/Chest Pain**
- ☐ **Arthritis**
- ☐ **Neurological Disorder**
- ☐ **Sleep Apnea**
- ☐ **Stomach Ulcer/Gastric Reflux**
- ☐ Joint Pain
- ☐ Joint Stffness
- ☐ Joint Redness/Swelling
- ☐ Infection
- ☐ Wheezing
- ☐ Pneumonia
- ☐ Recurring Cough
- ☐ Tuberculosis
- ☐ Difficulty Swallowing
- ☐ Loss of bladder control
- ☐ Loss of stool control

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

Disease	Relationship(s)
☐ Arthritis	_____
☐ Back Pain	_____
☐ Neck Pain	_____
☐ Migraine Headaches	_____
☐ Cancer	_____
☐ 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