The NSSC Spine Center-William D Hunter, MD PA
CURRENT AND PAST MEDICAL HISTORY

MRN: _____

NAME: _____ BIRTH DATE: ____/____/____ AGE: _____

GENDER: □ Male □ Female HEIGHT: _____ WEIGHT: _____ RIGHT OR LEFT HANDED: _____

ADDRESS: _____
Street City State Zip Code

PHONE NUMBER: Home (_____) _____ Mobile (_____) _____ Work (_____) _____

OCCUPATION: _____ EMPLOYER: _____

FAMILY PHYSICIAN: _____ PHONE NUMBER: (_____) _____

ADDRESS: _____
Street City State Zip Code

REFERRING PHYSICIAN: _____ PHONE NUMBER: (_____) _____

ADDRESS: _____
Street City State Zip Code

HOW DID YOU HEAR ABOUT US?

□ Friends/family □ Internet/Social media □ Newspaper □ Doctor/Physician referral: _____

□ Employee □ Other: _____

LIST ALL PHYSICIANS YOU ARE SEEING:

Doctor:	Reason you are seeing:
_____	_____
_____	_____
_____	_____
_____	_____

CURRENT PROBLEM:

Please describe your current problem, including how and when it began: _____

_____

_____

_____

Is this problem accident related? □ Yes □ No

Do you have an attorney? □ Yes □ No

If yes, list name:

_____

Is this a personal injury claim? □ Yes □ No

Is this problem work related? □ Yes □ No

Is this a Worker's Compensation claim?

□ Yes □ No

Have you had therapy/chiropractic care in the LAST 12 MONTHS?

□ Yes □ No How many treatments? _____

Where? _____

Have you had cortisone injections in your back or neck?

□ Yes □ No When? _____

By whom? _____

ALLERGIES:

Medication Name:	Reaction:	Medication Name:	Reaction:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any food allergies? _____

CURRENT MEDICATIONS: Include all prescribed medications, over-the-counter drugs, dietary supplements, vitamins, herbal supplements, inhalers, etc.

Medication Name:	Dosage:	Frequency:	Medication Name:	Dosage:	Frequency:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

SURGICAL HISTORY:

Year:	Surgery:	Surgeon/Hospital:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any bleeding problems because of surgery or when you shave? _____

Have you had a problem with infections? _____

SOCIAL HISTORY:

Tobacco	Do you use tobacco? □ Yes □ No □ Cigarettes – packs/day _____ □ Chew – #/day _____ □ Pipes – #/day _____ □ Cigars – #/day _____ If you previously used tobacco, what year did you quit? _____
Alcohol	Do you drink alcohol? □ Yes □ No If yes, what types of alcohol do you drink? Select all that apply □ Beer □ Wine □ Liquor How many drinks per week on average? _____
Drugs	Do you use currently use recreational or street drugs? □ Yes □ No If yes, which recreational or street drugs? _____ Have you ever taken street drugs with a needle? □ Yes □ No

Do you or have you ever had any of the following illnesses:
Hepatitis □ Yes □ No If yes, which kind? _____ Have you been treated? □ Yes □ No
HIV □ Yes □ No TB □ Yes □ No MRSA □ Yes □ No

HEALTH HISTORY: Check all medical problems

□ Anxiety
□ Arrhythmia
□ Asthma
□ Atrial fibrillation (A-fib)
□ Bipolar Disorder
□ Bleeding Disorder
□ Cancer
If yes, what kind? _____
Is it active or treated? _____
□ Congestive heart failure
□ Coronary artery disease
□ Cerebral vascular accident (CVA/stroke)
□ Depression
□ Diabetes
□ Deep vein thrombosis (DVT/blood clots)
□ Emphysema/COPD
□ Fibromyalgia
□ Gastroesophageal reflux (GERD)
□ Glaucoma
□ Headaches
□ Heart attack/MI
□ Hyperlipidemia/High cholesterol
□ Hypertension/High blood pressure
□ Kidney disease
□ Liver disease
□ Lung disease
□ Osteoporosis
□ Osteoarthritis
□ Parkinson's disease
□ Rheumatoid arthritis
□ Sleep apnea
□ Thyroid disease
□ Peripheral neuropathy
□ Peripheral vascular disease (PVD)

Other: _____
_____

REVIEW OF SYSTEMS: Have you had any problems with the following?

General:
□ Appetite loss
□ Fatigue
□ Night sweats
□ Unintentional weight gain
□ Unintentional weight loss

HEENT:
□ Headaches
□ Blurred vision
□ Loss of vision
□ Hearing loss
□ Ringing in the ears
□ Nasal congestion
□ Frequent nose bleeds
□ Sore throat
□ Hoarseness
□ Difficulty swallowing

Respiratory:
□ Shortness of breath
□ Wheezing
□ Chronic cough

Cardiovascular:
□ Chest pain
□ Palpitations/Racing heart
□ Leg swelling/Edema

Gastrointestinal:
□ Abdominal pain
□ Nausea
□ Vomiting
□ Heartburn
□ Change in bowel habits
□ Constipation
□ Diarrhea

Genitourinary:
□ Urinary frequency
□ Incontinence
□ Difficulty urinating
□ Blood in the urine
□ Frequent UTI's

Neurological:
□ Problems with speech
□ Dizziness
□ Tremor
□ Balance problems
□ Memory loss

WOMEN ONLY:
Do you experience heavy periods, irregularity, spotting, pain, or endometriosis? □ Yes □ No
Are you pregnant, trying for pregnancy, or breast feeding? □ Yes □ No
Number of pregnancies: _____ Number of live births: _____
MEN AND WOMEN: Number of children/ages _____

Reviewed by:

NSSC USE ONLY

The abovementioned is my complete medical history and I consent for treatment by signing below.

PATIENT SIGNATURE_____ DATE _____

PRINT NAME _____ DATE OF BIRTH _____