HEALTH HISTORY

Patient Name:		
Birth Date:		
Visit Date:		
Referring Physician:		
Reason for visit:		
Pharmacy:	Phone#	Fax#
Current Medications:	Dosage:	Frequency:

S. Blake Kelly, MD ● James Lynch, MD ● Nathan Overbey, MD.
Karie Stewart, APRN ● Stacy Torres, APRN ● Angela Quick, APRN ● Jennifer McReynolds, PA-C ● Matthew Munda, APRN ● Meredith Pruitt, PA-C ● Cody McBride, APRN
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List all pain medication taken in the last 2 weeks: ____

If you have Depression or anxiety, how well has it been controlled in the past 3 months?
Excellently Well Could be better Poorly

History of allergy or adverse reactions: (circle all that apply)

Antibiotic Allergy:	**Pain Medication:**	
Penicillin	Morphine (Kadian, Embeda, Avinza)	Demerol
Sulfa	Codeine (Tylenol #3)	Tramadol
Mycins	Hydrocodone (Norco, Lortab)	Toradol
Tetracycline/Doxycycline	Oxycodone (Percocet, Oxycotin)	Talwin
Cephalosporins	Fentanyl (Duragesic)	NSAIDs
Tape/Iodine	Dilaudid (Hydromorphone)	Tylenol
Other:_______________	Other: ________________	Other: ________

Social History: (Circle all that apply)

__ Drink Alcohol: Occasionally Frequently Daily
__ Use Tobacco ___ packs per day, how long? _____
__ Use street drugs or have a history of substance abuse/addiction
__ Admitted to the hospital for psychiatric treatment, date:___________
__ Admitted to the hospital for drug or alcohol treatment, date:__________

Are you pregnant or trying to become pregnant? Yes No

Marital Status: Married Single Widowed Number of children:___

Level of Education:___________ Occupation:________________ Employer:____________

Currently Working? Yes No Disabled? Yes No Permanent/temp? Date:_______

Are you or have you even been a victim of domestic violence or sexual abuse? Yes No

____

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Please list all current doctors involved in your care at this time:

Physician	**Specialty**	**Date of last appointment**
____________________________	____________________________	____________________________
____________________________	____________________________	____________________________
____________________________	____________________________	____________________________

Previous Treatments:	If yes, date of last treatment		
Physical/Occupational Therapy	Y	N	____________________________
Chiropractor/Manipulation	Y	N	____________________________
Acupuncture	Y	N	____________________________
Hypnosis	Y	N	____________________________
TENS unit	Y	N	____________________________
Psycho/Psychiatric Therapy	Y	N	____________________________

Tests:			
Lumbar MRI	Y	N	____________________________
Thoracic MRI	Y	N	____________________________
Cervical MRI	Y	N	____________________________
CT Scan	Y	N	____________________________
Myelogram	Y	N	____________________________
Nerve Conduction	Y	N	____________________________
Bone Scan	Y	N	____________________________
Discogram	Y	N	____________________________

Describe below any further pertinent health history.

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Medical History: (Please mark appropriate response)

Anemia, currently	yes no	Gastrointest. Disease	yes no	Neck pain	yes no
Arthritis (osteo or rheum)	yes no	Gout	yes no	Low back pain	yes no
Auto-immune disorder	yes no	Headaches (daily, migraine, tension)	yes no	Chronic pain, Area _____________	yes no
Anxiety	yes no	Heart disease	yes no	Knee pain, right left	yes no
Blood disease/Anemia	yes no	Hepatitis A _ B __ C__	yes no	Hip pain, right left	yes no
Bipolar disorder	yes no	High blood pressure	yes no	Foot/ankle, right left	yes no
Bone disease/Osteoporosis	yes no	High Cholesterol	yes no	Shoulder, right left	yes no
Blood Transfusion	yes no	HIV/AIDS	yes no	Wrist/hand, right left	yes no
Cancer - Type ___________________	yes no	Irritable bowel	yes no	Pelvic pain	yes no
Coronary Artery Disease	yes no	Kidney disease	yes no	Spinal Stimulator	yes no
Congestive Heart Failure	yes no	Kidney stone, number__	yes no	Neck, lumbar	
COPD/Emphysema	yes no	Liver disease	yes no		
Crohn's disease	yes no	Loss of consciousness	yes no		
Dementia	yes no	Pacemaker	yes no		
Diabetes	yes no	Psoriasis	yes no		
DVT/Blood clot	yes no	Schizophrenia	yes no		
Dysrhythmia	yes no	Seizure disorder	yes no		
Depression	yes no	Stroke/mini-stroke	yes no		
Frequent falls	yes no	Thyroid disease	yes no		
		Vascular disease	yes no		

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Surgical History: (Please mark the appropriate response)

Previous Surgery	yes no	Other surgical history:	Spinal Fusion, Date__________	yes no
Appendectomy	yes no	______________________	Neck Thoracic Lumbar	
Coronary Artery Bypass	yes no	______________________	Spinal Laminectomy, Date __________	yes no
Cardiac Procedure	yes no	______________________	Neck Thoracic Lumbar	
Gall bladder removal	yes no	______________________	Epidural Steroid Injection	yes no
			Neck, date ______________	
Hernia	yes no	______________________	Lumbar, date ______________	
Hysterectomy	yes no	______________________	Thoracic, date ______________	
Joint replacement , Area_______________	yes no		Rhizotomy (nerve ablation)	yes no
Neck/Lumbar	yes no		Neck Thoracic Lumbar	
Neck/Lumbar	yes no			
Tonsillectomy	yes no		Vertebral Disc replacement	yes no
Vascular procedure	yes no		Date: _____________	
			Neck Lumbar	

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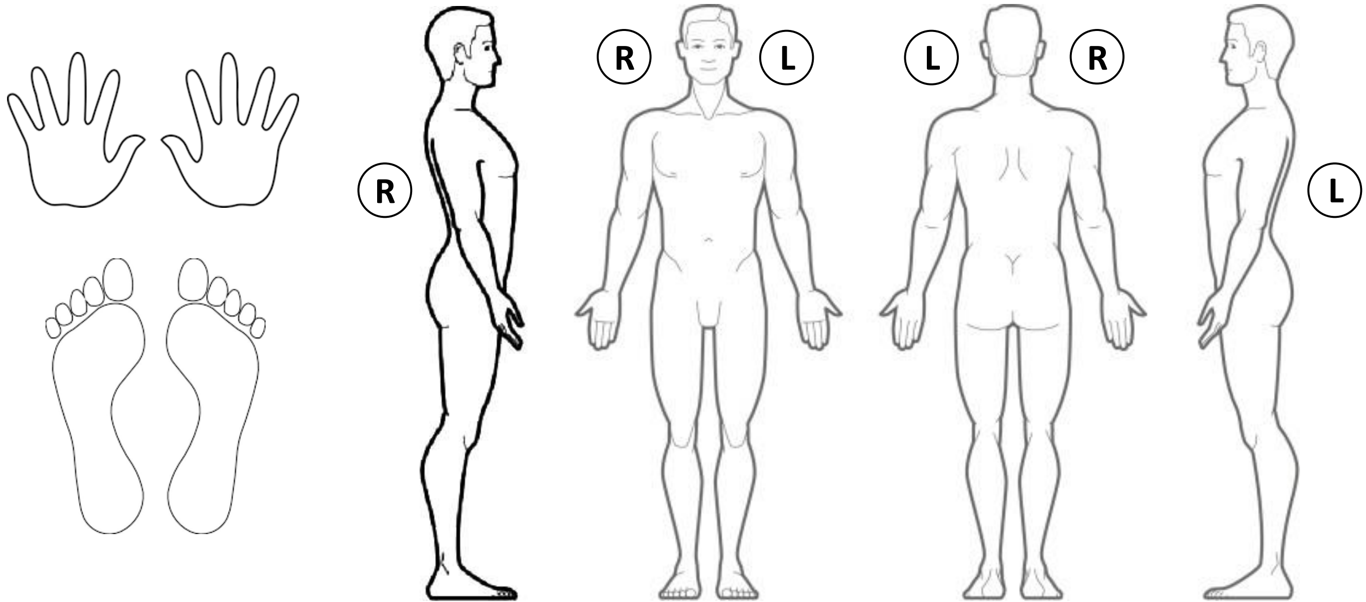
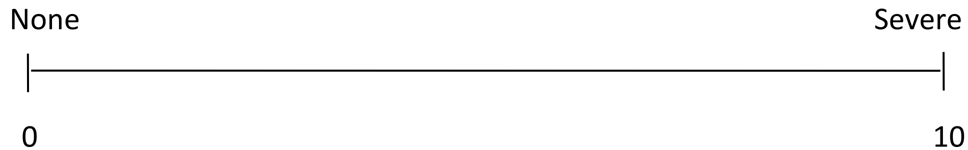
On the diagram, shade in the areas where your pain is located.



Mark your level of pain on this scale



Circle a <u>FEW</u> words that best describe your pain

Flickering	Pricking	Pinching	Tugging	Hot	Tingling
Quivering	Boring	Pressing	Pulling	Burning	Itchy
Pulsing	Drilling	Gnawing	Wrenching	Scalding	Smarting
Pounding	Stabbing	Cramping	Crushing	Searing	Stinging
Dull	Tender	Cool	Annoying	Spreading	Tight
Sore	Tiring	Cold	Troublesome	Radiating	Numb
Hurting	Exhausting	Freezing	Miserable	Penetrating	Drawing
Aching	Nagging	Unbearable	Intense	Piercing	Squeezing

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