SpineTeam OKLAHOMA
at Tulsa Bone & Joint Associates

Main clinic: 4802 South 109th East Ave. • Tulsa, OK 74146 • P: 918.392.1400
www.SpineTeamOklahoma.com

YOUR MEDICAL HISTORY page 1

1 Patient information Chart #_

Today's Date_____

Referring Doctor_____

Last Name_____ First Name_____ MI____

Date of Birth (M/D/Y)_____ Age_____

Sex (M/F)_____ Height_____ Weight_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

2 Your symptoms

Are your symptoms mostly in back, neck or elsewhere?

_____

How long have you had these symptoms?

☐ 6 weeks ☐ 7 - 12 weeks ☐ 4 months or more

Do you have pain radiating past your knee or elbow? ☐ Yes ☐ No

Does your leg or arm ever go numb? ☐ Yes ☐ No

Have you lost bowel or bladder control? ☐ Yes ☐ No

The pain is: ☐ Constant ☐ It comes & goes

Does your pain wake you up at night? ☐ Yes ☐ No

hat things makes the pain better? (rest, ice, heat, pills)

_____

What makes the pain worse? (sitting, standing, lifting)

_____

Do you have pain that radiates into the arm or leg? ☐ Yes ☐ No

(If yes, describe)_____

Lost any control over bowel or bladder functions? ☐ Yes ☐ No

(If yes, describe)_____

Any weakness or numbness in an arm or leg? ☐ Yes ☐ No

(If yes, describe)_____

How long can you: Sit_____ Stand_____ Walk_____

Is your pain the result of a: ☐ Fall ☐ Auto accident ☐ Other (list)

_____

3 Current status

Is there a law suit pending on problem? ☐ Yes ☐ No

Which of the following describes you currently?

☐ Working: if yes: ☐ Full duties ☐ Limited

☐ Not working because of back or neck problem

☐ Not working because of another health problem

☐ Homemaker, retired or unemployed

How long have you been at that job?_____

Does your job require lifting, standing, sitting? ☐ Yes ☐ No

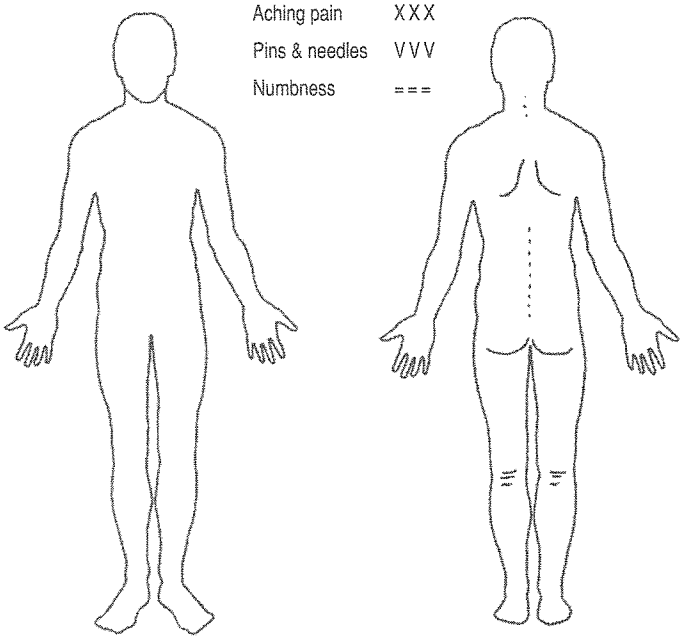
Employer at time of injury:_____

4 Your pain

Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.

FRONT BACK

Stabbing pain	////
Burning pain	OOO
Aching pain	XXX
Pins & needles	VVV
Numbness	===



Circle your pain level on a scale of 1 to 10, with 10 being unbearable pain.

1 2 3 4 5 6 7 8 9 10

no pain extreme pain

Reviewed by_____ Date_____

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YOUR MEDICAL HISTORY page 2

5 Previous treatments & tests

Name of the doctor that treated you FIRST for this problem and the city:

What treatments did you have?

What tests have you had? ☐ CT scan ☐ MRI ☐ X-ray ☐ EMG

☐ Other (list)

Did you have any injections for your problem? ☐ Yes ☐ No

(if yes, describe)

Did these injections help? ☐ Yes ☐ No

(If yes, describe)

Did you have previous back or neck surgery? ☐ Yes ☐ No

(If yes, describe)

List any other PREVIOUS SURGERIES you had, and dates:

Have you ever had a blood transfusion? ☐ Yes ☐ No

(If yes. describe)

Did you have physical therapy before for your problem? ☐ Yes ☐ No

(If yes. describe)

Did this therapy help? ☐ Yes ☐ No

(If yes. describe)

Do you do any special exercises for your back or neck? ☐ Yes ☐ No

(If yes, describe)

List any medications you are taking:

What other medications have you tried?

What do you hope we can accomplish today?

What other concerns do you have?

6 Your health

List any ALLERGIES you have to medications, foods, etc.

Do you have any adverse reactions to anesthesia? ☐ Yes ☐ No

(If yes, describe)

Do you smoke? ☐ Yes ☐ No (If yes, how many packs a day?)

Do you drink alcohol? ☐ Yes ☐ No (If yes. how many days a week?)

Do you have any of the following medical problems:

AIDS/HIV	☐ Yes	☐ No	Nerve problems	☐ Yes	☐ No
Arthritis or joint pain	☐ Yes	☐ No	Psychiatric problems	☐ Yes	☐ No
Bleeding disorders	☐ Yes	☐ No	Stomach problems	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Thyroid problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Anxiety/Depression	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Recently. have you had:		
Heart problems	☐ Yes	☐ No	Fever or chills	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Weight loss	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Chest pain	☐ Yes	☐ No
Migraines/headaches	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No
Muscle diseases	☐ Yes	☐ No	Worse pain at night	☐ Yes	☐ No
Swollen ankles	☐ Yes	☐ No	Night sweats	☐ Yes	☐ No

Other problems:

7 Your family history

Do any family members have a history of:

Back/neck problems	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
AIDS/HIV	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No
Arthritis or joint pain	☐ Yes	☐ No	Migraines/headaches	☐ Yes	☐ No
Bleeding disorders	☐ Yes	☐ No	Muscle diseases	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Nerve problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric problems	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Stomach problems	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No	Thyroid problems	☐ Yes	☐ No

Other problems?

Reviewed by _____ Date _____