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PALOMAR SPINE & PAIN

INTERIM HEALTH HISTORY

Patient Name: ________________________________ Birthdate: ___________Today's Date: _________

Do you have a new home address Yes No ____

Do you have a new telephone number Yes No Home:_______________**Cell:**___________________

Do you have new health insurance Yes No ____

What is the main area of your pain today? ____

What is your pain scale presently? 0 1 2 3 4 5 6 7 8 9 10

Since your last visit, has your pain level: ____ Increased _____ Decreased _____ Stayed the Same

Are you involved in physical therapy, chiropractic, massage therapy or other treatments?
____

If so, how has it affected your pain? _____ Better _____ Same _____ Worse
When is your pain worse? ____ Morning _____ Afternoon _____ Night _____ All the Time

Associated with my pain, I also have or am experiencing: _____ Loss of Coordination ____ Weakness

____ Loss of Dexterity _____ Increased Sensitivity _____ Decreased Sensitivity _____ Numbness

Have you experienced any of the following symptoms since your last visit?

____ Fatigue ____ Diarrhea ____ Fever ____ Constipation ____ Insomnia ____ Nausea _____ Heartburn
____ Loss of Appetite ____ Serious Depression ____ Chest Pain (Angina) ____ Aggression ____ Dizziness
____ Hostility _____ Shortness of Breath ____ Mood Swings

Since your last visit, have you:

1) Seen any other doctors? [ ] yes [ ] no If so, whom? ____

2) Had any other diagnostic tests? [ ] yes [ ] no If so, which tests and where did you have them done?
____

3) Started any new treatments? [ ] yes [ ] no If so, what treatment and who ordered it?________________
____

4) Started taking any new medications? [ ] yes [ ] no If so, which ones and at what dosage? ______________
____

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Are any of them blood thinners? [ ] yes [ ] no If so, which ones?________________________________

5) Developed any new allergies? [ ] yes [ ] no If so, which ones? ___________________________________

6) If Female: Are you Pregnant? [ ] yes [ ] no. Is there a chance you may be Pregnant? [ ] yes [ ] no

7) Had any surgeries? [ ] yes [ ] no. If yes, what kind? ____

8) Developed any new medical problems from the following list? Please "X" any that apply:

[ ] depression or anxiety
[ ] pulmonary embolus
[ ] major blood vessel
[ ] congestive heart failure
[ ] bleeding tendency
[ ] abnormal heart rhythm
[ ] high blood pressure
[ ] chronic bronchitis
[ ] joint disease or arthritis
[ ] deep venous thrombosis
[ ] peripheral vascular disease
[ ] thyroid disease
[ ] kidney disease
[ ] urinary tract infections
[ ] seizures/epilepsy
[ ] rheumatoid arthritis
[ ] ulcer or stomach problems
[ ] other nervous system diseases
[ ] shingles
[ ] syphilis
[ ] lupus
[ ] asthma
[ ] emphysema
[ ] heart attack
[ ] liver disease
[ ] tuberculosis
[ ] cancer. What type?______________
[ ] hepatitis
[ ] chicken pox
[ ] meningitis
[ ] osteoporosis
[ ] stroke
[ ] diabetes
[ ] osteoarthritis
[ ] pancreatitis

9) Who is your primary care physician? ____

If available Phone #: ( ) ________________ Fax #: ( ) _________________

LIST OF MEDICATIONS**

Name of Medication: _______________________
Dosage (mg.): ____________________________
Directions: ______________________________

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Dosage (mg.): ____________________________
Directions: ______________________________

****Use the back of this sheet for additional medications**

*****PLEASE ALLOW 72 HOURS FOR RETURN CALLS REGARDING MEDICATION*****