IGEN Medical History

Spine Patient

Today's Date_____/_____/_____ **Please use black or blue ink - Please print**

Primary Care Physician | Referring Doctor Name | Physician of Record

Patient Information

Patient Name | Home Phone | Work Phone | Cell Phone

Address | City | State | Zip | Social Security No.

Date of Birth | Age | If under age 17, provide parent/guardian name(s)/phone number | ☐ Male ☐ Female | email address

Employer | Occupation

Race ☐ Asian ☐ Black or African American ☐ White ☐ Native American ☐ Multiracial ☐ Other_____

Ethnic Group ☐ Hispanic ☐ Non-Hispanic

Preferred language ☐ English ☐ Spanish ☐ German ☐ French ☐ Other_____

Relationship Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other_____

Name of spouse/partner/significant other (living with you)* | Daytime phone

*This person will be indicated as your primary contact in case of emergency

Please provide name and telephone number of a family member or friend (not living with you) for use in case of emergency.

Name | Relationship | Daytime Phone

Who is your Power of Attorney?

Name | Relationship | Daytime Phone

Do you have a Living Will? ☐ Yes ☐ No

Insurance Information

Name of Insured | Insured's Date of Birth | Policy Number

Insurance Company | Employer | Work Number

Personal Injury

Is the reason for your office visit an illness/injury resulting from an automobile accident? ☐ Yes ☐ No

If Yes, specify the following: Date of accident_____ State where accident occured _____

Name of auto insurance provider _____

Workers' Compensation Information

Diagnoses recognized on claim_____

State_____ Date of Injury_____ Claim #_____

Managed Care (MCO) Provider_____ MCO Phone_____

Employer at time of injury_____ ☐ Claim Allowed ☐ Claim Litigated

Patient Name_____ **Medical Record No.**_____

Vital Signs/History of Present Illness

Date of Birth	Age	☐ Male ☐ Female	☐ Right handed ☐ Left handed	Height	Weight	Blood Pressure	Pulse

What are your current symptoms?_____

What did your physician tell you about your spine problem?_____

Where is your pain located?

☐ neck	☐ left hand	☐ middle back	☐ left upper leg	☐ right upper leg
☐ upper back	☐ right shoulder	☐ lower back	☐ left shin/calf	☐ right shin/calf
☐ left shoulder	☐ right upper arm	☐ right buttock	☐ left foot	☐ right foot
☐ left upper arm	☐ right forearm	☐ left buttock	☐ left toes	☐ right toes
☐ left forearm	☐ right hand	☐ left hip	☐ right hip	☐ other_____

If more than one location is checked, where is your pain the worst?_____

Severity of pain (circle one): 0 1 2 3 4 5 6 7 8 9 10 (0 = no pain 10 = worst pain)

The pain is ☐ constant ☐ intermittent ☐ sharp/stabbing ☐ dull/aching

Does your pain radiate to the arm? If so, to which part? Check all that apply.

☐ above the elbow ☐ below the elbow ☐ the hand

Does your pain radiate to the leg? If so, to which part? Check all that apply.

☐ the outside of the leg ☐ the inside of the leg ☐ the top of the leg ☐ the back of the leg

Do you experience numbness or tingling? If so, where? Check all that apply and circle "R" for right or "L" for left.

☐ arm: R / L ☐ foot: R / L ☐ leg: R / L ☐ neck ☐ upper back ☐ other_____

☐ fingers: R / L ☐ hand: R / L ☐ toes: R / L ☐ midback ☐ low back _____

Do you experience weakness? If so, where? Check all that apply and circle "R" for right or "L" for left.

☐ arm: R / L ☐ leg: R / L ☐ foot: R / L ☐ other_____

The symptoms began as a result of ☐ an injury at work ☐ a motor vehicle accident ☐ an injury outside of work

☐ spontaneously with no known cause **What was the date of the accident or injury?** _____

Explain how it happened _____

These symptoms have been present for ☐ 1-7 days ☐ 8-14 days ☐ 14-21 days ☐ 1 month ☐ 2 months

☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ greater than 12 months

These symptoms started on (give specific date, if known)_____

These symptoms improve when you ☐ stand ☐ walk ☐ sit ☐ lie down ☐ change positions ☐ never improve

These symptoms worsen when you ☐ stand ☐ walk ☐ sit ☐ lie down ☐ change positions ☐ never improve

Has there been any change in your daily activities due to these symptoms? ☐ no ☐ yes

Since what date have you been unable to perform your daily routine?_____

Are you able to work with your condition? ☐ no ☐ yes

Since the onset of symptoms, have you experienced any <u>new</u> problems urinating or having bowel movements? ☐ no ☐ yes

Previous Diagnostic Tests

Check any of the following diagnostic tests, or treatments you have had for this illness or injury

	Mo./Yr.	Where		Mo./Yr.	Where
Plain x-rays	__/__	_____	Bone scan	__/__	_____
MRI scan	__/__	_____	Myelogram	__/__	_____
CT scan	__/__	_____	Other	__/__	_____
EMG/NCV	__/__	_____			

Previous Treatment

Have you had chiropractic treatment in the last 12 months? ☐ yes ☐ no If yes, please answer the following:

Who is the chiropractor?_____

When was your first visit? _____

How many times have you gone?_____

Did your symptoms improve? ☐ yes ☐ no

Treatment types:

☐ electrical stimulation ☐ physical conditioning
☐ ultrasound ☐ massage
☐ excercises ☐ hot packs
☐ ice ☐ traction
☐ manipulation ☐ other_____

Have you had physical therapy in the last 12 months? ☐ yes ☐ no If yes, please answer the following:

Who is the physical therapy provider?_____

When was your first visit? _____

How many times have you gone?_____

Did your symptoms improve? ☐ yes ☐ no

Treatment types:

☐ aquatics ☐ ice
☐ electrical stimulation ☐ physical conditioning
☐ ultrasound ☐ hot packs
☐ massage ☐ traction
☐ excercises ☐ other_____
☐ manipulation

Have you had epidural steroid injections (ESI) in the last 12 months? ☐ yes ☐ no If yes, please answer the following:

How many injections have you had?_____ When was your first one? _____

Did your symptoms improve? ☐ yes ☐ no When was your last one?_____

Medication History

List all current medications, including "over the counter" medications, prescription medications, and herbal supplements.

Name	Dose	Directions	Name	Dose	Directions

Are you taking blood thinners? ☐ yes ☐ no If yes, which? ☐ aspirin ☐ Coumadin ☐ Plavix ☐ other_____

Do you give IGEN permission to obtain your medication information electronically through our medical records system?
☐ yes ☐ no

Your Pharmacy Name_____ **Phone**_____

Allergies

Are you allergic to any medications? ☐ yes ☐ no **If yes, which medicine?**_____

What happens?_____

Are you allergic to ☐ iodine ☐ contrast dye ☐ shellfish ☐ latex ☐ tape ☐ metals/jewelry

What happens?_____

Do you have any other allergies? ☐ yes ☐ no **If yes, what are you allergic to?**_____

What happens? _____

Have you ever had an allergic reaction to a blood transfusion? ☐ yes ☐ no

Past Surgical/Medical History

Have you ever had any neck or back operations/surgery? ☐ yes ☐ no

If yes, when?_____ Surgeon's name_____

Describe area of spine operated_____

Have you ever had a surgery on your chest? ☐ yes ☐ no

If yes, describe the surgery_____

Have you ever had any other operations/surgery? ☐ yes ☐ no

If yes, when?_____ Describe the surgery_____

Have you been diagnosed with any of the following? (check all that apply)

☐ anemia
☐ angina/chest pain
☐ arrhythmia/irregular heartbeat
☐ asthma
☐ congestive heart failure
☐ coronary artery disease
☐ diabetes
☐ elevated cholesterol
☐ elevated triglycerides
☐ heart attack
☐ heart disease
☐ high blood pressure
☐ kidney disease
☐ lung disease/COPD/emphysema
☐ malignancy/cancer
☐ malignant hyperthermia
☐ mental health disorder/ depression/anxiety
☐ osteoporosis
☐ peripheral vascular disease
☐ phlebitis/bleeding disorder
☐ sleep apnea
☐ staph infection (e.g. MRSA)
☐ stroke
☐ thyroid disease

If yes, explain _____

Do you have any other medical conditions? ☐ yes ☐ no
If yes, explain_____

Have you ever been treated for blood clots or excessive bleeding? ☐ yes ☐ no
Is there any reason you cannot receive blood or blood products? ☐ yes ☐ no

If yes, explain_____

Have you ever had angioplasty? ☐ yes ☐ no
Do you have any stents placed? ☐ yes ☐ no If yes, when?_____
Do you have any other implant devices (i.e., pacemaker, morphine pump, spinal cord stimulator)? ☐ yes ☐ no
Explain_____

Have you had a flu shot? ☐ yes ☐ no If yes, when?_____
Have you had a pneumonia vaccine? ☐ yes ☐ no If yes, when?_____

Social History

Are you a veteran? ☐ yes ☐ no

Do you live alone? ☐ yes ☐ no

Indicate your marital status ☐ single ☐ married ☐ widowed ☐ divorced ☐ partner

If married, does your spouse work? ☐ yes ☐ no

Are you pregnant? ☐ yes ☐ no **If yes, when is your due date?**_____

Do you have any children? ☐ yes ☐ no

If yes, indicate sex, age(s) and whether they live at home_____

_____

Do you currently use or have you ever used any tobacco products? ☐ yes ☐ no ☐ in the past, but quit

If "yes", specify ☐ cigarettes ☐ chewing tobacco ☐ snuff tobacco ☐ cigars ☐ pipe

How much/day?_____For how many years?_____

If "in the past, but quit", when did you quit? _____

Do you currently drink alcohol? ☐ yes ☐ no ☐ recovering alcoholic, since _____

If yes, specify ☐ beer ☐ wine ☐ liquor

How many drinks/week?_____For how many years? _____

Do you currently use or have you ever used any recreational drugs? ☐ yes ☐ no ☐ in the past, but quit

If "yes", specify ☐ marijuana ☐ cocaine ☐ speed ☐ hallucinogens ☐ narcotics ☐ other

How much/day?_____For how many years?_____

If "in the past, but quit", when did you quit?_____

Have you ever received treatment for drug and/or alcohol problems? ☐ yes ☐ no

If yes, specify when and where_____

Have you ever been exposed to radiation? ☐ yes ☐ no **Chemicals?** ☐ yes ☐ no

If yes, describe_____

Work History

Highest grade level achieved in school ☐ grade school ☐ high school ☐ college ☐ post college

Are you currently employed? ☐ yes ☐ no ☐ retired

Employer_____**Length of employment** _____

Job title_____**How long have you done this job?**_____

If employed, are you currently working with these symptoms? ☐ yes ☐ no

Does your job require you to:

☐ lift____pounds ☐ use a computer ☐ bend ☐ reach over head
☐ sit ☐ lift over head ☐ drive a truck or forklift ☐ stand

If not currently working, did a physician place you off work? ☐ yes ☐ no

If yes, please list physician's name _____

If not currently working, when did you stop working? _____

Family History

Has a parent, sibling or offspring had any of the following conditions? Please check all that apply and indicate the relationship of the person who has/had the condition.

Condition	Relationship (mother, father, sister, brother, son, daughter)
☐ Alzheimer's/memory loss	
☐ aneurysm	
☐ blood clots/clotting disorders	
☐ depression/mental problems	
☐ diabetes	
☐ heart problems	
☐ high blood pressure	
☐ kidney disease	
☐ life threatening complications to anesthesia	
☐ lung problems	
☐ malignant hyperthermia	
☐ multiple sclerosis	
☐ Parkinson's disease	
☐ stroke	
☐ brain tumor	
☐ breast tumor	
☐ cervical tumor	
☐ colon cancer	
☐ kidney cancer	
☐ leukemia	
☐ liver cancer	
☐ lung cancer	
☐ lymphoma	
☐ ovarian cancer	
☐ pancreatic cancer	
☐ prostate cancer	
☐ skin cancer	
☐ spine tumor	
☐ thyroid cancer	
☐ cancer-other _____	
☐ other problems _____	

Review of Systems

Do you currently have any of the following problems (please answer "Yes" or "No" to every item; do not skip any):

GENERAL
fever ☐ yes ☐ no
chills ☐ yes ☐ no
sweats ☐ yes ☐ no
anorexia ☐ yes ☐ no
fatigue ☐ yes ☐ no
malaise (body weakness) ☐ yes ☐ no
weight loss ☐ yes ☐ no

EYES
blurring ☐ yes ☐ no
diplopia (double vision) ☐ yes ☐ no
eye irritation ☐ yes ☐ no
eye discharge ☐ yes ☐ no
vision loss ☐ yes ☐ no
eye pain ☐ yes ☐ no
photophobia (sensitivity to light) ☐ yes ☐ no

EAR/NOSE/THROAT
earache ☐ yes ☐ no
ear discharge ☐ yes ☐ no
tinnitus (ringing in ears) ☐ yes ☐ no
decreased hearing ☐ yes ☐ no
nasal congestion ☐ yes ☐ no
nosebleeds ☐ yes ☐ no
sore throat ☐ yes ☐ no
hoarseness ☐ yes ☐ no
dysphagia (difficulty swallowing) ☐ yes ☐ no

HEART
chest pains ☐ yes ☐ no
palpitations ☐ yes ☐ no
syncope (passing out) ☐ yes ☐ no
difficulty breathing on exertion ☐ yes ☐ no
difficulty breathing when sitting/standing ☐ yes ☐ no
peripheral edema ☐ yes ☐ no

RESPIRATORY
cough ☐ yes ☐ no
difficulty breathing ☐ yes ☐ no
excessive sputum ☐ yes ☐ no
hemoptysis (spitting up blood) ☐ yes ☐ no
wheezing ☐ yes ☐ no

GASTROINTESTINAL
nausea ☐ yes ☐ no
vomiting ☐ yes ☐ no
diarrhea ☐ yes ☐ no
constipation ☐ yes ☐ no
change in bowel habits ☐ yes ☐ no
abdominal pain ☐ yes ☐ no
melena (black or tarry stool) ☐ yes ☐ no
bloody stool ☐ yes ☐ no
jaundice ☐ yes ☐ no

PSYCHIATRIC
depression ☐ yes ☐ no
anxiety ☐ yes ☐ no
memory loss ☐ yes ☐ no
hallucinations ☐ yes ☐ no
other mental health problems ☐ yes ☐ no

GENITOURINARY
vaginal discharge ☐ yes ☐ no
incontinence ☐ yes ☐ no
difficulty urinating ☐ yes ☐ no
urinating blood ☐ yes ☐ no
urinary frequency ☐ yes ☐ no
amenorrhea (no menstrual cycle) ☐ yes ☐ no
menorrhagia (excessive menstrual flow) ☐ yes ☐ no
abnormal vaginal bleeding ☐ yes ☐ no
pelvic pain ☐ yes ☐ no

MUSCULOSKELETAL
back pain ☐ yes ☐ no
neck pain ☐ yes ☐ no
joint pain ☐ yes ☐ no
joint swelling ☐ yes ☐ no
muscle cramps ☐ yes ☐ no
muscle weakness ☐ yes ☐ no
stiffness ☐ yes ☐ no
arthritis ☐ yes ☐ no

SKIN
rash ☐ yes ☐ no
itching ☐ yes ☐ no
dryness ☐ yes ☐ no
suspicious lesions ☐ yes ☐ no

NEUROLOGIC
intermittent paralysis ☐ yes ☐ no
weakness ☐ yes ☐ no
paresthesia (prickly/tingling sensation) ☐ yes ☐ no
seizures ☐ yes ☐ no
syncope (passing out) ☐ yes ☐ no
tremors ☐ yes ☐ no
vertigo (dizziness) ☐ yes ☐ no
numbness ☐ yes ☐ no
imbalance ☐ yes ☐ no
incoordination ☐ yes ☐ no
headache ☐ yes ☐ no
visual changes ☐ yes ☐ no
tinnitus (ringing in ears) ☐ yes ☐ no

ENDOCRINE
cold intolerance ☐ yes ☐ no
heat intolerance ☐ yes ☐ no
polydipsia (excessive thirst) ☐ yes ☐ no
polyphagia (excessive eating) ☐ yes ☐ no
polyuria (excessive urination) ☐ yes ☐ no
weight change ☐ yes ☐ no

HEMATIC/LYMPHATIC
abnormal bruising ☐ yes ☐ no
abnormal bleeding ☐ yes ☐ no
enlarged lymph nodes ☐ yes ☐ no

ALLERGY
urticaria (itching) ☐ yes ☐ no
hay fever ☐ yes ☐ no

IMMUNOLOGIC
persistent infections ☐ yes ☐ no
HIV exposure ☐ yes ☐ no

Patient signature_____ **Date**_____

IGEN physician signature _____ **Date**_____