

**Alabama Orthopedic, Spine & Sports Medicine Associates**

52 Medical Park Drive East, Suite 115  
Birmingham, Alabama 35235  
205-838-3900

**PATIENT HISTORY**

Please PRINT and fill out completely.

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Hand Dominance:  Left  Right

**HISTORY OF INJURY**

Did the problem result from a specific injury?  Yes  No **Injury/Accident Date:** \_\_\_\_\_

Did your problems begin following:  Work injury?  Motor Vehicle Accident? **What State?** \_\_\_\_\_

How did you get injured? \_\_\_\_\_

If neither, how long have you had the condition? \_\_\_\_\_

Please rate your pain on a scale of 1 to 10 (10 being the most painful): \_\_\_\_\_

Is the pain:  Constant  Occasional  Sharp  Dull  Aching  Stabbing  Throbbing

What symptoms are you experiencing?  Locking  Catching  Giving Way  Popping  Grinding  Other

What, if anything, makes your symptoms *better*? \_\_\_\_\_

What, if anything, makes your symptoms *worse*? \_\_\_\_\_

Have you seen another physician for this injury?  Yes  No

If yes, who? \_\_\_\_\_

What treatments have you tried?  Nothing  Physical Therapy  Exercise  Acupuncture  
 Chiropractic  Injections (specify: ESI, Facets, Sacroiliac, Selective Nerve Root Block, Synvisc, Hyalgan)  
 Medications \_\_\_\_\_  Other \_\_\_\_\_

Have you had any of the following tests?

Test	Date (month/year)	What facility? (clinic/hospital)
<input type="checkbox"/> X-rays	_____	_____
<input type="checkbox"/> MRI scan	_____	_____
<input type="checkbox"/> CT scan	_____	_____
<input type="checkbox"/> EMG/NCV	_____	_____
<input type="checkbox"/> Discogram	_____	_____
<input type="checkbox"/> EKG	_____	_____
<input type="checkbox"/> Blood tests	_____	_____
<input type="checkbox"/> Other	_____	_____

**Regular Exercise:**  Yes  No Type of exercise and activity you enjoy: \_\_\_\_\_

\_\_\_\_\_

**Health History- page 2**

Patient name \_\_\_\_\_

Practitioner's Initials: \_\_\_\_\_

**PAST SURGICAL HISTORY**

Please check any previous surgical procedures, list the date and describe surgery:

- Appendectomy       Hernia Repair       Arthroscopy Lower extremity       Upper extremity
- Spine/Back Surgery       Heart Surgery       Total Joint Replacement       Fracture Repair
- Other: \_\_\_\_\_

**SOCIAL HISTORY**

- Special Diet:       Yes       No      Any restrictions? \_\_\_\_\_
- Tobacco Use:       Yes       No      Type: \_\_\_\_\_      Duration: \_\_\_\_\_      Quit Date: \_\_\_\_\_
- Alcohol Use:       Yes       No      Frequency: \_\_\_\_\_
- Drug Use:       Yes       No      Frequency: \_\_\_\_\_
- Caffeine Use:       Yes       No      Frequency: \_\_\_\_\_

**ALLERGIES**

Are you allergic to any medication? **Sulfa**  Yes  No      **Latex**  Yes  No       No known drug allergies

Please list all medications that you are allergic to: \_\_\_\_\_

**MEDICAL HISTORY**

Please check current or previous medical conditions:

- Anemia       Depression       Hepatitis A or B       Osteoporosis
- Arthritis       Diabetes       High Blood Pressure       Rheumatoid Arthritis
- Asthma       Emphysema       HIV       Stroke/Seizures
- Blood Clots       Heart Disease       Irregular Heartbeat       Thyroid
- Cancer       Liver Disease       Chemical Dependency and/or Alcoholism
- Other \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No      If yes, when? \_\_\_\_\_

**MEDICATIONS**

Please list all medications you are currently taking. Include antibiotics, blood thinners, insulin, heart medications, aspirin, and any over the counter medications. Include Vitamin, Mineral and Herb supplements.

<i>Medication</i>	<i>Dosage</i>	<i>Frequency</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**GASTROINTESTINAL HISTORY**

Do you have a history of Peptic Ulcer Disease?  Yes  No      If yes, when? \_\_\_\_\_

Do you have a history of GI, stomach bleed?  Yes  No      If yes, when? \_\_\_\_\_

Do you take any medications for your stomach? (Please include over the counter medications; i.e. Pepcid, Tums, Zantac, etc., dosage and frequency). \_\_\_\_\_

Have you ever taken anti-inflammatory medicine for a period greater than 30 days? (Please include over the counter medications such as Advil, Aleve, and previously prescribed medications, such as Celebrex, and Vioxx. List all you have tried). \_\_\_\_\_

Practitioner's Initials: \_\_\_\_\_

**FAMILY HISTORY**

Please check family history conditions:

- Blood Clots       Diabetes       Hypertension       Rheumatoid Arthritis
- Cancer       Heart Disease       Osteoporosis       Stroke / Seizures

Please describe any immediate family history of medical problems: \_\_\_\_\_

**REVIEW OF SYSTEMS**

Check if you have current symptoms or current known medical problems in the following areas. Please describe. If you do not have any problems please check in the negative box.

- 1. CONSTITUTIONAL GENERAL       None       Weight loss     Weight Gain     Insomnia     Chronic Fatigue  
 Other \_\_\_\_\_
- 2. EYES       None       Vision change     Glasses/Contacts     Cataracts     Glaucoma  
 Other \_\_\_\_\_
- 3. EARS, NOSE, THROAT       None       Loss of hearing     Seasonal Allergies     Sinus Pain     Ringing  
 Other \_\_\_\_\_
- 4. CARDIOVASCULAR       None       Chest Pain     Edema     Hypertension     Palpitations  
 High cholesterol       Other \_\_\_\_\_
- 5. RESPIRATORY       None       Asthma       Wheezing       Frequent Cough  
 Other \_\_\_\_\_
- 6. GASTROINTESTINAL       None       Heartburn     Indigestion     Acid Reflex     Ulcer Problems  
 Abdominal Pain       Peptic Ulcer     GI, Stomach Bleed  
 Other \_\_\_\_\_
- 7. MUSCULOSKELETAL       None       Arthritis     Muscle Weakness     Joint Pain     Back Pain  
 Other \_\_\_\_\_
- 8. SKIN       None       Rash       Ulcers       Scars  
 Other \_\_\_\_\_
- 9. NEUROLOGICAL       None       Headaches     Seizures     Numbness     Dizziness  
 Other \_\_\_\_\_
- 10. PSYCHIATRIC       None       Depression     Crying     Anxiety     Mood Swing  
 Other \_\_\_\_\_
- 11. ENDOCRINE       None       Diabetes     Hypothyroid     Hyperthyroid     Hot Flashes  
 Other \_\_\_\_\_
- 12. HEMATOLOGY       None       Easy Bruising     Bleeding     Anemia  
 Other \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print name: \_\_\_\_\_

