

Carolina Spine Center

Medical History First Name: _____ Last Name: _____ Middle Initial: _____

Age: _____ Sex: Male _____ Female _____ Height: _____ Weight: _____ Pain:(0-10) _____

Chief Complaint Describe your problem and what treatments you've have had: _____

When did your symptoms begin? _____

What Doctors have you seen for this problem & related tests: _____

Past Medical History (Ex: High Blood Pressure, Heart Disease, Diabetes).

List all major illnesses and conditions you have ever been diagnose with: _____

Past Surgeries: _____

Family History Please list any serious medical conditions that run in your family: _____

Social History Tobacco: Yes No Amount/How often? _____

Alcohol: Yes No Amount/How often? _____

Current occupation: _____ Last day worked: _____ Marital Status: _____

Medications List all current medications with dosages, include over the counter meds & vitamins:

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

Drug Allergies Include Latex, Iodine/ChloroPrep or Iohexol (X-ray dye) if applicable:

1. _____ 3. _____

2. _____ 4. _____