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/ChloraPrep or Iohexol (X-ray dye) if applicable:

1. _____ 3. _____
2. _____ 4. _____