

# New Patient History

**Patient Name:**

**Today's Date:**

**Please list Physician or Chiropractor to send medical report to:**

<b>Name</b>	
<b>Street Address</b>	
<b>City, State, Zip Code</b>	
<b>Phone</b>	

Please fill out all sections:

The information gathered in the Review of Medical Symptoms and Medical History is utilized to aid in the decision making process as it applies to spinal conditions. It is not intended as a component in a general medical exam for general health purposes. Any information gathered in this review may be utilized by the patient for consultation and review by a physician of the patient's choice. Dr. Dillin is a spinal surgery specialist and does not review this section to discover new or old medical problems that do not directly impact his decisions as they apply to the spine. He does not offer general medical advice or comment on this medical area which is not within his sub-specialty training in spinal surgery. Any positive responses in this section should be reviewed by your primary care physician.

Instructions to Fill Out Form

1. ► **Please print all the answers** ◀
2. ► **Please mark an answer in each category** ◀

**Social History**

**Work History: Please choose best answer**

<input type="checkbox"/> working	<input type="checkbox"/> unemployed	<input type="checkbox"/> retired	<input type="checkbox"/> working at home	<input type="checkbox"/> fired or laid off	<input type="checkbox"/> disability due to work injury
<input type="checkbox"/> working modified duty		<input type="checkbox"/> Disability due to a medical condition			

**Smoking History: Please choose best answer**

<input type="checkbox"/> never smoked	<input type="checkbox"/> smoked but quit	<input type="checkbox"/> currently smoking
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**Medical History**

**1. Your Past Medical History: If Yes then fill out below or choose ► ( ) None**

<input type="checkbox"/> allergy to anesthetics	<input type="checkbox"/> anemia	<input type="checkbox"/> ankylosing spondylitis	<input type="checkbox"/> asthma
<input type="checkbox"/> blood transfusion in past	<input type="checkbox"/> bleeding disorders	<input type="checkbox"/> cancer	<input type="checkbox"/> cirrhosis
<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> depression	<input type="checkbox"/> diabetes	<input type="checkbox"/> emphysema
<input type="checkbox"/> gastric or peptic ulcer	<input type="checkbox"/> gout	<input type="checkbox"/> heart attack	<input type="checkbox"/> heart failure
<input type="checkbox"/> heart disease	<input type="checkbox"/> hepatitis	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> immune deficiency disease
<input type="checkbox"/> kidney disease	<input type="checkbox"/> liver disease	<input type="checkbox"/> lung disease	<input type="checkbox"/> lupus
<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> osteoporosis	<input type="checkbox"/> Parkinson's disease	<input type="checkbox"/> peripheral vascular disease
<input type="checkbox"/> pulmonary embolism	<input type="checkbox"/> psoriasis	<input type="checkbox"/> rheumatoid arthritis	<input type="checkbox"/> seizure
<input type="checkbox"/> stroke	<input type="checkbox"/> thyroid disease	<input type="checkbox"/> thrombophlebitis	<input type="checkbox"/> ulcerative colitis

Please list any medical diagnoses/conditions not included in the list above:

**2. Allergy to Medications:** If Yes then fill out below or choose ► ( ) None

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**3. Current Medications:** If Yes then fill out below or choose ► ( ) None

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**4. Prior Operations:** If Yes then fill out below or choose ► ( ) None

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**5. Family History:** If Yes then fill out below or choose ► ( ) None

( ) allergy to anesthetics	( ) anemia	( ) asthma	( ) bleeding disorders
( ) cancer	( ) diabetes	( ) heart disease	( ) high blood pressure
( ) kidney disease	( ) liver disease	( ) seizure	( ) stroke

Please list any Family History not included in the list above:

**6. Review of Symptoms:** If Yes then fill out below or choose ► ( ) None

(also see next page for continuation)

**Constitutional ▼**

chills	fatigue	fever	weight loss
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**Eyes ▼**

blurred vision	cataracts	double vision	glaucoma	pain	vision loss
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**ENT ▼**

bleeding gums	ear ringing	hearing loss	hoarseness	loss of taste
nasal polyps	nosebleeds	sore throat	swallowing difficulty	vertigo

**Cardiovascular ▼**

chest pain	leg swelling	palpitations	shortness of breath
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**Respiratory ▼**

cough	coughing up blood	sputum production	wheezing
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**Gastrointestinal ▼**

abdominal pain	black tarry stools	diarrhea	heartburn	jaundice
nausea	rectal bleeding	reflux	vomiting	vomiting blood

**Musculoskeletal ▼**

general muscle stiffness	joint pain	joint stiffness	muscle cramps
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**Integumentary ▼**

rashes	itching
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**Neurologic ▼**

ataxia: gait disorder	coma history	confusion	fainting or blackouts	headaches	history of paralysis
involuntary movements	memory loss	numbness or tingling	seizure	speech difficulties	tremor

**Psychiatric ▼**

depression	disorientation	hallucinations	mood changes
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**Endocrine ▼**

cold intolerance	excessive hunger	excessive thirst	heat intolerance
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**Hematologic ▼**

bleeding tendencies	easy bruising
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**Allergic/Immunologic ▼**

history of recurrent infections	night sweats
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**Genitourinary ▼**

difficulty urinating	incontinence	discharge	blood in urine
burning urination	change in urination pattern	painful urination	excessive night urination

Please list any symptoms not included in the list above: