

Return Patient History

Patient Name:

Today's Date:

Please list Physician or Chiropractor to send medical report to:

Name	
Street Address	
City, State, Zip Code	
Phone	
Fax	

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.

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

Interval Event History

1. Interval Spine Trauma History ► (EVENTS SINCE LAST OFFICE VISIT ONLY)

<input type="checkbox"/> No <input type="checkbox"/> Yes	New injury to involved spine area (non-work related)
<input type="checkbox"/> No <input type="checkbox"/> Yes	New injury to involved spine area (work related)
<input type="checkbox"/> No <input type="checkbox"/> Yes	New injury to involved spine area not addressed in last office visit
<input type="checkbox"/> No <input type="checkbox"/> Yes	New injury to different spine area (non-work related)
<input type="checkbox"/> No <input type="checkbox"/> Yes	New injury to different spine area (work related)

► If Yes is chosen, please provide details.

2. Interval Trauma History ► (EVENTS SINCE LAST OFFICE VISIT ONLY)

<input type="checkbox"/> No <input type="checkbox"/> Yes	New injury to a different body part (not work related)
<input type="checkbox"/> No <input type="checkbox"/> Yes	New injury to a different body part (work related)
<input type="checkbox"/> No <input type="checkbox"/> Yes	New trauma due to sports
<input type="checkbox"/> No <input type="checkbox"/> Yes	New fall
<input type="checkbox"/> No <input type="checkbox"/> Yes	New trauma due to motor vehicle accident (MVA)
<input type="checkbox"/> No <input type="checkbox"/> Yes	Other trauma

► If Yes is chosen, please provide details.

3. Interval Social History: current Work status (please check one)

<input type="checkbox"/>	Working at usual occupation
<input type="checkbox"/>	Working modified duty
<input type="checkbox"/>	Retired
<input type="checkbox"/>	Temporarily disabled
<input type="checkbox"/>	Permanently disabled
<input type="checkbox"/>	Unemployed
<input type="checkbox"/>	Vocational rehabilitation
<input type="checkbox"/>	Not working in formal job setting

4. Interval Non-Spinal Medical History ► (EVENTS SINCE LAST OFFICE VISIT ONLY)

<input type="checkbox"/> No <input type="checkbox"/> Yes	New non-spinal medical problem since last office visit
<input type="checkbox"/> No <input type="checkbox"/> Yes	Hospitalization since last office visit
<input type="checkbox"/> No <input type="checkbox"/> Yes	Emergency room visit since last office visit
<input type="checkbox"/> No <input type="checkbox"/> Yes	Newly prescribed non-spinal diagnostic tests for non-spinal (medical) condition since last visit
<input type="checkbox"/> No <input type="checkbox"/> Yes	New non-spinal surgical procedure since last office visit
<input type="checkbox"/> No <input type="checkbox"/> Yes	New medication prescribed since last office visit

► If Yes is chosen, please provide details.

5. Review of Symptoms: If symptoms identified, then fill out below or choose ► () None

Constitutional ▼

chills	fever	weight loss
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Cardiovascular ▼

chest pain	leg swelling	palpitations	shortness of breath
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Respiratory ▼

coughing up blood	wheezing
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Gastrointestinal ▼

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

Musculoskeletal ▼

joint pain	joint stiffness
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Integumentary ▼

rashes	itching
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Neurologic ▼

ataxia: gait disorder	headaches	confusion	fainting or blackouts	seizure
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Psychiatry ▼

depression	disorientation
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Hematologic ▼

bleeding tendencies	easy bruising
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Genitourinary ▼

incontinence	blood in urine
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