MendelsonKornblum
Orthopedic & Spine Specialists

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History of Present Illness Form

Patient Name:	Birth Date: Age: Gender: ☐Male ☐Female
Who Referred you to us: ☐ Hospital program ☐ Physician Referral ☐ Insurance Referral ☐ Advertisement ☐ Internet/Website ☐ Friend/Family Name:_____	Primary Care Physician:_____ Phone # Referring Physician: _____ Phone # Pharmacy Name: _____ Pharmacy Location: _____ Phone #
Height: Weight:	

What is the reason for your visit?

Body Part _____ ☐Right ☐Left ☐Both

Was there an injury? ☐ Yes ☐ No Job Related? ☐ Yes ☐ No Auto Accident? ☐ Yes ☐ No Date of onset/injury: Where did it happen? Are you currently on disability? ☐ Yes ☐ No	Explain what happened:

Circle your pain level: No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable

Reset

Describe the location of your pain: _____

Check the quality of your pain: ☐ Dull ☐ Sharp ☐ Electrical ☐ Burning ☐ Pins & Needles

What makes the pain better?: _____

What make the pain worse?:_____

List any prior Ortho related treatments: ☐Physical Therapy ☐ Injections ☐Other (Explain):

Have you had previous studies such as:

MRI	Date:_____	Facility:_____
CAT Scan	Date:_____	Facility:_____
EMG	Date:_____	Facility:_____
Bone Scan	Date:_____	Facility:_____
X-rays	Date:_____	Facility:_____
Ultrasound	Date:_____	Facility:_____
Blood work	Date:_____	Facility:_____
Other(Explain)	Date:_____	Facility:_____

Medical History

Past Medical History: Have you ever had any of the following: Check all that apply, provide explanation in space below.

☐ AIDS/HIV	☐ Blood Transfusions	☐ High Blood Pressure	☐ Neurological Disease
☐ Anxiety/Depression	☐ Cancer	☐ High Cholesterol	☐ Pacemaker
☐ Arthritis	☐ Diabetes	☐ Kidney Disease	☐ RSD
☐ Autoimmune Disorder	☐ Fibromyalgia	☐ Liver Disease/Hepatitis	☐ Stomach Ulcer
☐ Bleeding Disorder	☐ Gout	☐ Lung Disease	☐ Stroke
☐ Blood Clots	☐ Heart Disease	☐ Major Infection	☐ Thyroid Disease

Please explain:

Family History

Mother	Father
Living: ☐ Yes ☐ No ☐ Unknown. Diseases: ☐ No known significant family history ☐ Unknown ☐ Significant (add below)	Living: ☐ Yes ☐ No ☐ Unknown. Diseases: ☐ No known significant family history ☐ Unknown ☐ Significant (add below)

Are you Jehovah's Witness? ☐Yes ☐No Are you willing to accept blood/blood products? ☐Yes ☐No

Surgical History

Month/Year	Orthopedic	Month/Year	General
Have you ever had a reaction to anesthesia? ☐ Yes ☐No			

Social History

Occupation/Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Number of children _____

Do you smoke/use tobacco? ☐ Yes ☐ No How much? _____

Did you in the past? ☐ Yes ☐ No How long? _____ Date you quit: _____

Do you drink alcohol? ☐ Yes ☐ No Type/Weekly amount _____

Did you in the past? ☐ Yes ☐ No Type/Weekly amount _____

Allergies (Drug)

Allergic to	Reaction
Are you allergic to Latex? ☐ Yes ☐ No	Can you take aspirin? ☐ Yes ☐ No

Medications

Medication	Dose	Frequency

Pain

Medication	Dose	Frequency
Vit/Supp	**Dose**	**Frequency**

Review of Symptoms

Indicate “yes” or “no” to any symptoms you have had in recent months. Indicate which symptoms you have had if multiple symptoms are listed.

Symptom	Yes	No
Skin rash, sore, or excessive bruising?		
Numbness or tingling?		
Fever, night sweats, or chills?		
Frequent nosebleeds?		
Cough, shortness of breath, wheezing, or asthma?		
Chest pain or pressure?		
Exposed to anyone with tuberculosis?		
Blacked out, lost consciousness or had a seizure?		
Abnormal swelling of legs or feet?		
Pain in the calves of your legs when you walk?		
Change in bowel or bladder habits? (ie. incontinence)		
Pain, stiffness, or swelling in your joints or back?		
Do you feel you are at risk for HIV or AIDS?		
Muscle weakness?		
Dizziness or falling?		
Travel outside the US?		

Who do you authorize us to speak to regarding your medical care? Please list below:

Name	Relationship

E-Signature of Patient_____ Date: _____
Patient Legal Representative (if applicable)_____ Date: _____
Print name of Legal Representative _____ Relationship: _____

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Billing Information Form

Patient Last Name	Patient First Name	MI
Mailing Address		
City	State	Zip Code
Home Phone	Cell Phone	Work Phone
Email Address	Date of Birth	Social Security Number
Emergency Contact	Relationship	Contact's Phone ☐ Home ☐ Cell ☐ Work

Responsible Party

Last Name	First Name

Is this an auto or work comp? ☐ Worker Comp ☐ Auto

Claim # _____ Date of Injury: _____

Insurance Carrier: _____

Adjuster's Name: _____

Phone #: _____

Do you have an attorney? ☐ Yes ☐ No

Attorney Name: _____

Attorney's Phone #: _____

Primary Insurance Coverage	Subscriber	Gender ☐ M ☐ F	DOB:
Contract/ID Number	Group/Policy Number	Relationship: ☐ Self ☐ Spouse ☐ Dependent	
Secondary Insurance Coverage	Subscriber	Gender ☐ M ☐ F	DOB:
Contract/ID Number	Group/Policy Number	Relationship: ☐ Self ☐ Spouse ☐ Dependent	

Patient signature: _____ Date: _____

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Lower Back/Cervical Spine Questionnaire

Date:_____

Patient Name:	Patient ID #	Birth Date	Age	Height	Weight (lbs)

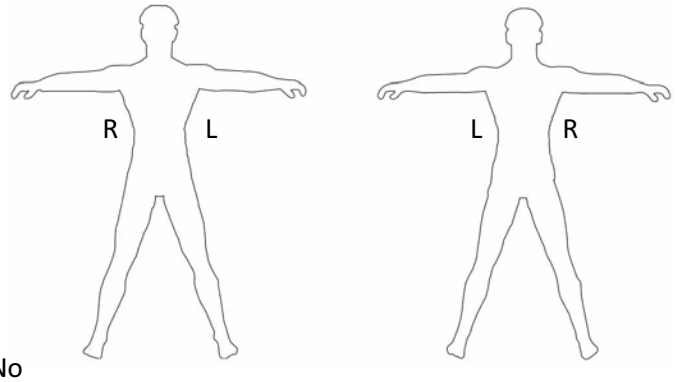
1. Rate your pain on a scale of 0 – 10.
   0 = No pain and 10 = worst pain

   _____Neck _____Right Arm _____Left Arm

   _____Back _____Right Leg _____Left Leg

2. **Please mark the location of your pain and other symptoms on the picture below.**

   X = Pain and O = Numbness/Tingling



3. Do you have numbness or tingling?

   Right Arm: ☐ Yes ☐ No **Left Arm:** ☐ Yes ☐ No

   Right Leg: ☐ Yes ☐ No **Left Leg:** ☐ Yes ☐ No

4. When did your pain start?

   Neck_____

   Back_____

5. Was there an injury that caused the pain? ☐ Yes ☐ No

   If yes, explain_____

6. Have you had a prior history of: **Neck Pain** ☐ Yes ☐ No **Back Pain** ☐ Yes ☐ No

   If yes, explain_____

   _____

7. Since your symptoms began, have you had any of the following treatments? *(please check all that apply and explain)*

   ☐ Medications If yes, explain_____

   ☐ Physical Therapy If yes, explain_____

   ☐ Injections If yes, explain_____

   ☐ Bracing If yes, explain_____

8. Are you working? ☐ Yes ☐ No If yes, what do you do?_____

9. Have you had prior neck/back surgery? ☐ Yes ☐ No

   If yes, please explain _____

10. Do you have any of the following? *(please check all that apply)*

    ☐ Fever or chills ☐ Recent weight loss ☐ Loss of bowel bladder control

    ☐ Night pain: Is the night pain worse than activity pain? ☐ Yes ☐ No

11. Do you smoke? ☐ Yes ☐ No

12. Do you drink alcohol? ☐ Yes ☐ No

Patient signature:_____ Date:_____