MendelsonKornblum
Orthopedic & Spine Specialists

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:____________ Address:____________ Town/zip:____________ 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: 1 (No Pain) 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:

Study	Date	Facility
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

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

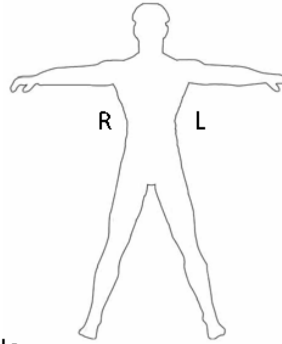
   ______Neck ______Right Arm ______Left Arm

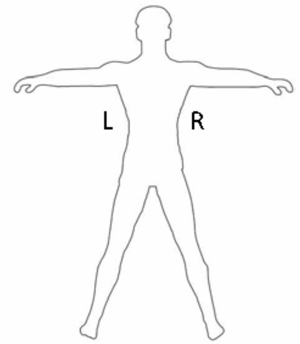
   ______Back ______Right Leg ______Left Leg

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

   X = Pain and O = Numbness/Tingling

   FRONT **BACK**





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: __________