Johnson Medical Center

PERSONAL INFORMATION

Printed Name (First, Middle, Last): _____

Preferred Name: _____ **SSN:** _____-_____-_____

Date of Birth: _____/_____/_____ **Age:**_____ **Sex: M or F**

Marital Status: S M D W **Spouse's Name:** _____ **# of Children:** _____

Home Phone: (_____)_____-_____ **Mobile Phone:** (_____)_____-_____ **Work Phone:** (_____)_____-_____

Email: _____ **Work Email:** _____

Preferred Method of Contact: _____ **Cell Carrier:** _____ **Okay to send SMS texts? Y or N**

Primary Physician's Name: _____ **City/State:** _____ **Phone #:** (_____)_____-_____

Referred by (Patient/Physician): _____

Occupation (Or Retired from): _____ **Employer:** _____ **Years on Job:** _____

Home Address: _____

_____

Northern Address: _____

_____

EMERGENCY CONTACT(S)

Name #1: _____ **Relationship:** _____ **Phone #:** (_____)_____-_____

Name #2: _____ **Relationship:** _____ **Phone #:** (_____)_____-_____

INSURANCE INFORMATION

****Please give your Photo ID and Insurance Card(s) to the receptionist to copy.****

Primary Insurance Provider: _____ **Plan Type:** _____ **Claim #:** _____

Policy ID #: _____ **Group #:** _____ **Effective Date:** ____/____/_____

Policy Holder Name: _____ **Relationship to Patient:** _____ **Policy Holder D.O.B.:** ____/____/_____

Policy Holder SSN: _____-_____-_____ **Insurance Provider Phone #:** (_____)_____-_____

Secondary Insurance Provider: _____ **Plan Type:** _____ **Claim #:** _____

Policy ID #: _____ **Group #:** _____ **Effective Date:** ____/____/_____

Policy Holder Name: _____ **Relationship to Patient:** _____ **Policy Holder D.O.B.:** ____/____/_____

Policy Holder SSN: _____-_____-_____ **Insurance Provider Phone #:** (_____)_____-_____

AGREEMENT

We appreciate you taking the time to complete this Medical History form.
All information is confidential.

The information that I will provide in this Medical History form is true and accurate to the best of my knowledge.

Signature: _____ Date: ____/____/_____

****Please return to the receptionist.****

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CHIEF COMPLAINT/CONDITION

What is your worst area of pain/symptoms? _____

_____

When did it start and how? _____

_____

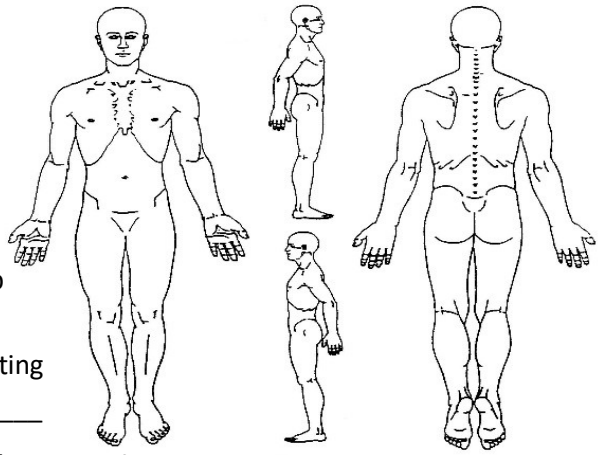
Does it radiate/spread? If so, where? _____

Use the pain scale described below to rate your pain for the questions below:

0. Pain free.
1. Very minor annoyance, occasionally minor twinges.
2. Minor annoyance, occasionally strong twinges.
3. Annoying enough to be distracting.
4. Can be ignored if you are really involved in your work/task, the still distracting.
5. Cannot be ignored for more than 30 minutes.
6. Cannot be ignored for any length of time, but you can still go to work or school and participate in activities.
7. Makes it difficult to concentrate, interferes with sleep, but she can still function with effort.
8. Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain.
9. Unable to speak, crying out or moaning uncontrollably, near delirium.
10. Unconscious, pain makes you pass out.

Please rate your pain on a 0 to 10 scale.	
Your pain right now?	_____
Your worst pain?	_____
Your least pain?	_____

Use this diagram to indicate the location.



Check all that describe your pain

☐ Achy ☐ Hot/Burning ☐ Cramping ☐ Cutting ☐ Dull ☐ Itching ☐ Numb
☐ Sharp ☐ Shock-like ☐ Shooting ☐ Sore ☐ Spasms ☐ Stabbing ☐ Stiff
☐ Throbbing ☐ Tight ☐ Tingling (Pins & Needles) ☐ Weak ☐ Tiring/Exhausting
☐ Other: _____

When is your pain at it's worse? ☐ Morning ☐ During the day ☐ Evening ☐ Middle of the night

What word describes the frequency of pain? ☐ Constant ☐ Intermittent

Since your condition started, your symptoms have: ☐ Increased ☐ Decrease ☐ Remained the same ☐ Erratic

What makes your condition worse? _____

_____

What makes your condition better? _____

_____

What activities are adversely/negatively affected by your pain? ☐ Enjoyment of life ☐ Normal work ☐ Sleep
☐ General activities ☐ Recreational ☐ Activities ☐ Walking ☐ Mood ☐ Relationship with people
☐ Other or Examples: _____

Your condition is: ☐ Forgotten with Activity ☐ Interfering with Activity ☐ May Prevent Activity ☐ Preventing Activity

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Please note all areas of pain and/or symptoms:

☐ Headaches	☐ Mid Back	☐ Eyes	☐ Low Back
☐ Sinus headaches	☐ Ribs	☐ Ears	☐ Sacroiliac Joints (S-I Joints)
☐ Neck	☐ Chest	☐ Nose	☐ Hips
☐ Shoulders	☐ Abdomen	☐ Jaw (TMJ)	☐ Thighs
☐ Arms	☐ Heartburn	☐ Tinnitus	☐ Knees
☐ Elbows	☐ Urinary	☐ Dizziness	☐ Legs
☐ Wrists / Hands / Fingers	☐ Bowel	☐ Memory	☐ Ankles / Feet / Toes

Please mark all of the following you have undergone prior to today's visit:

□ Massage □ Acupuncture □ Chiropractic □ Physical Therapy □ Podiatry Treatment □ Pain Medication □ Muscle Relaxants

□ Steroid Shots (Circle all that apply) Cervical / Thoracic / Lumbar / Shoulder / Elbow / Wrist / Hip / Knee / Feet

□ Facet Injections (Circle all that apply) Cervical / Thoracic / Lumbar

□ Radiofrequency Ablation (circle all that apply) Cervical / Thoracic / Lumbar

□ Trigger Point Injections. Where: _____

□ Vertebroplasty/Kyphoplasty. Where: _____

□ Nerve Blocks. Where: _____

□ Spine Surgery /Spine Fusion. Where: _____

□ Permanent Spinal Column Stimulator. Where: _____

□ Other: _____

Diagnostic Test and Imaging	**Date**	**Facility**
X-Rays of the _____	_____	_____
MRI of the _____	_____	_____
CAT scan of the _____	_____	_____
EMG/NCV study of the _____	_____	_____
Ultrasound of the _____	_____	_____
Other Diagnostic testing: _____	_____	_____

Doctors seen for your current chief complaint:

Date	Doctor's Name	Type of Doctor	Test Ordered	Diagnosis / Treatment	Response

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GENERAL HEALTH HISTORY

Age: _____ **Height:** _____ft. _____in. **Weight:** _____lbs. **Handedness:** ☐ Left ☐ Right ☐ Ambidextrous

Any electronic/metal implants?	☐ Yes ☐ No	_____
Can you take NSAID's (Aspirin / Advil)?	☐ Yes ☐ No	_____
Use of Alcohol?	☐ Yes ☐ No	If yes, how often? _____
Use of Tobacco?	☐ Yes ☐ No	If yes, how often? _____
Use of Drugs?	☐ Yes ☐ No	If yes, how often? _____
Do you drink coffee/soda?	☐ Yes ☐ No	If yes, how often? _____
Do you exercise?	☐ Yes ☐ No	_____
Do you sleep throughout the night?	☐ Yes ☐ No	_____
Excessive exposure at home or work to:	☐ fumes ☐ dust ☐ solvents ☐ airborne particles ☐ noise	

Past Medical History

General Medical
- ☐ Cancer-Type _____
- ☐ Diabetes-Type _____
- ☐ Transplant Recipient
- ☐ HIV/ARC

Hepatic
- ☐ Hepatitis A (Active/Inactive/Unsure)
- ☐ Hepatitis B (Active/Inactive/Unsure)
- ☐ Hepatitis C (Active/Inactive/Unsure)

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis

Musculoskeletal
- ☐ Amputation
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Lower Back Pain
- ☐ Chronic Neck Pain
- ☐ Chronic Joint Pain
- ☐ Fibromyalgia
- ☐ Joint Injury
- ☐ Osteoarthritis
- ☐ Osteoporosis/Osteopenia
- ☐ Phantom Limb Pain
- ☐ Rheumatoid Arthritis
- ☐ Tennis Elbow
- ☐ Vertebral Compression Frx
- ☐ Scoliosis

Head/Eyes/Ears/Nose/Throat
- ☐ Headaches
- ☐ Head Injury
- ☐ Thyroid Disease
- ☐ Migraines
- ☐ Glaucoma

Neurophysiological
- ☐ Alcohol Abuse
- ☐ Alzheimer's Disease
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Epilepsy
- ☐ Seizures
- ☐ Multiple Sclerosis
- ☐ Peripheral Neuropathy
- ☐ Schizophrenia
- ☐ CRPS
- ☐ Reflex Sympathetic Dystrophy

Genitourinary/Nephrology
- ☐ Bladder Infections
- ☐ Dialysis
- ☐ Kidney Infections
- ☐ Kidney Stones
- ☐ Urinary Incontinence

Cardiovascular/Hematologic
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Mitral Valve Prolapse
- ☐ Murmur
- ☐ Pacemaker/Defibrillator
- ☐ Phlebitis
- ☐ Poor Circulation
- ☐ Stroke/TIA/A-Fib

Gastrointestinal
- ☐ Bowel Incontinence
- ☐ Irritable Bowel Syndrome
- ☐ Heartburn (GERD)
- ☐ Gastrointestinal Bleeding
- ☐ Constipation

☐ **Other Diagnosed Conditions:** _____

Family Health History

- ☐ Diabetes
- ☐ Arthritis
- ☐ Dislocated Joints
- ☐ Headaches
- ☐ Scoliosis
- ☐ Seizures
- ☐ High Blood Pressure
- ☐ Rheumatic Fever
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Liver Problems
- ☐ Asthma
- ☐ Sinus Trouble
- ☐ Cancer - Type
- ☐ Other: _____
- ☐ Kidney Problems
- ☐ Osteoporosis
- ☐ Mental/Emotional
- ☐ HIV/ARC

☐ **I have no significant family history**

☐ **I am adopted. No medical history available.**

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Family History of Disease/Death:

	Age	Disease	Cause Of Death, If Deceased:
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Medication

Medication	Dose	Frequency	Medication	Dose	Frequency
1.			**7.**		
2.			**8.**		
3.			**9.**		
4.			**10.**		
5.			**11.**		
6.			**12.**		

Do you have any allergies? ☐ Yes ☐ No **Check if allergic to** ☐ Iodine ☐ Tape ☐ Shellfish ☐ Latex

Please list all medications you are allergic to:

Medication Name: **Allergic Reaction Type:**

_____

_____

_____

_____

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including dates, type, and any pertinent details.

Abdominal Surgery
☐ Gallbladder _____
☐ Appendectomy _____
☐ Other: _____
_____

Joint Surgery
☐ Shoulder _____
☐ Hip _____
☐ Knee _____
☐ Other: _____
_____

Heart Surgery
☐ Bypass _____
☐ Valve Replacement _____
☐ Aneurysm Repair _____
☐ Other: _____
_____

Spine/Back Surgery
☐ Discectomy (Levels) _____
☐ Laminectomy _____
☐ Spinal Fusion _____
_____

Please list any other surgeries and dates: _____
_____

☐ **I have never had any surgical procedure done.**

Female Surgeries
☐ Caesarean Section _____
☐ Hysterectomy _____
☐ Laparoscopy _____
☐ Ovarian _____
☐ Other: _____
_____

Other Common Surgeries
☐ Hemorrhoid Surgery _____
☐ Hernia Repair _____
☐ Thyroidectomy _____
☐ Tonsillectomy _____
☐ Vascular Surgery _____
☐ Skin Cancer _____

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Review of Systems

Constitutional (Check all that apply)

- ☐ Excessive Sweating
- ☐ Insomnia
- ☐ Chills
- ☐ Excessive Thirst
- ☐ Night Sweats
- ☐ Fatigue
- ☐ Difficulty Sleeping
- ☐ Low Sex Drive
- ☐ Weakness
- ☐ Easily Bruising
- ☐ Fever
- ☐ Unexplained Weight Gain
- ☐ Unexplained Weight Loss

Respiratory (Check all that apply)

- ☐ Cough
- ☐ Shortness of Breath On Exertion
- ☐ Shortness of Breath at Rest
- ☐ Wheezing
- ☐ History of Pulmonary Embolism

Eyes/Ears/Nose/Throat/Neck (Check all that apply)

- ☐ Recent Visual Changes
- ☐ Nosebleeds
- ☐ Dental Problems
- ☐ Earaches
- ☐ Recurrent Sore Throats
- ☐ Ringing in the Ear
- ☐ Hearing Problems
- ☐ Eye Pain
- ☐ Sinus Problems
- ☐ Allergies

Gastrointestinal (Check all that apply)

- ☐ Abdominal Cramps
- ☐ Hernia
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Dark and Tarry Stools
- ☐ Acid Reflex

Neurological (Check all that apply)

- ☐ Instability When Walking
- ☐ Numbness
- ☐ Dizziness
- ☐ Headaches
- ☐ Carpal Tunnel Syndrome
- ☐ Tingling
- ☐ Seizures

Cardiovascular (Check all that apply)

- ☐ Fainting
- ☐ Bleeding Disorders,
- ☐ High Blood Pressure
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Swelling in the Feet
- ☐ Lightheadedness
- ☐ Shortness of Breath During Sleep
- ☐ History of Deep Vein Thrombosis

Genitourinary/Nephrology (Check all that apply)

- ☐ Erectile Dysfunction
- ☐ Blood in Urine
- ☐ Flank Pain
- ☐ Pelvic Pressure
- ☐ Decreased Urine Flow
- ☐ Painful Urination

Psychiatric (Check all that apply)

- ☐ Suicidal Thoughts
- ☐ Suicidal Planning
- ☐ Depression
- ☐ Feeling Anxious
- ☐ Stress

ADDITIONAL SPACE

****Please use the additional space provided below for any additional information.****