Robert D. Heros, MD * Jason G. Anderson, MD * Tyler G. Huntington, PA-C * Margaret Baker, FNP

HEALTH HISTORY

Patient Name: ____ Date of Birth:________________________________

Who referred you to us?____

Occupation: ____________________________ Primary Care Provider: ____ **Is this a:** [ ] Workman's Comp Claim *or* [ ] Motor Vehicle Accident

Do you have a lawyer for this injury? [ ] Yes [ ] No

Is English your primary language? [ ] Yes [ ] No If no, which language? ____________________________

IN THE PAST 2 WEEKS, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? *(Check all that apply)*

[ ]	Fever	[ ]	Chills	[ ]	Night Sweats	[ ]	Insomnia
[ ]	Involuntary Weight Loss	[ ]	Headache	[ ]	Sore Throat	[ ]	Visual Difficulty
[ ]	Ringing In Ear	[ ]	Seizures/Tremors	[ ]	Sinus Congestion	[ ]	Chest Pain
[ ]	Palpitations	[ ]	Wheeze/Cough	[ ]	Nausea/Vomiting	[ ]	Stomach Pain
[ ]	Diarrhea	[ ]	Rash	[ ]	Blood In Urine/Stool	[ ]	Easy Bruising
[ ]	Joint Pain/Swelling	[ ]	Swelling	[ ]	Excessive Thirst/Appetite	[ ]	Fainting
[ ]	Recent Bleeding	[ ]	Shortness of Breath	[ ]	Loss of Bowel/Bladder Control	[ ]	Hearing Loss

PAIN HISTORY

Date of onset of present pain (date of injury or accident): ____

CAUSE OF PAIN:

[ ]	Motor Vehicle Accident	[ ]	Accident at Work	[ ]	Accident Away from Work	[ ]	Sports
[ ]	Unknown Cause	[ ]	Other:				

PAIN LOCATION:

[ ]	Left Side	[ ]	Right Side	[ ]	Both Sides				
[ ]	Headache	[ ]	Neck	[ ]	Shoulder	[ ]	Leg/Foot	[ ]	Arm/Hand
[ ]	Chest	[ ]	Upper Back	[ ]	Mid Back	[ ]	Abdomen	[ ]	Low Back
[ ]	Buttock	[ ]	Other:						

PAIN QUALITY:

[ ]	Burning	[ ]	Throbbing	[ ]	Aching	[ ]	Stabbing	[ ]	Numbness
[ ]	Tingling	[ ]	Weakness	[ ]	Shooting	[ ]	Dull	[ ]	Sharp
[ ]	Other:								

PAIN DURATION:

[ ]	Occasional	[ ]	Off and On	[ ]	Quick/Shooting	[ ]	Frequent	[ ]	Daily	[ ]	Constant

ACTIVITIES THAT MAKE PAIN WORSE:

[ ]	Sitting	[ ]	Standing	[ ]	Walking	[ ]	Bending Forward
[ ]	Arching Backwards	[ ]	Rotational Movement	[ ]	Driving	[ ]	Rest/Sleep

TIMES OF PAIN:

[ ]	In The Morning	[ ]	In The Evening	[ ]	With Certain Movements	[ ]	During Rest	[ ]	During of After Activity

ACTIVITIES THAT MAKE PAIN BETTER:

[ ]	Sitting	[ ]	Standing	[ ]	Walking	[ ]	Movement
[ ]	Lying Down	[ ]	Leaning Forward	[ ]	Leaning Back	[ ]	Heat
[ ]	Ice	[ ]	Rest	[ ]	Other:		

6464 SW Borland Rd., Suite A-2 Tualatin OR 97062

P: 503-885-1515 **F:** 503-885-1520 **E:** moreinfo@spinaldx.com **W:** www.spinaldx.com

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Patient Name: ____ Date of Birth: ______________________

Height: ______________ Weight : ______________

DO YOU HAVE A SIGNIFICANT HISTORY OR CURRENTLY HAVE:

Y	N	NEURO	
		Seizures	Last:
		Stroke/TIA	Date:
		Glaucoma	
		Numbness/Weakness/Paralysis	
		Bell's Palsy/Parkinson's	Dementia **YES** **NO**

Neurologist: ______________________

Opthamologist: ______________________

Y	N	CARDIOVASCULAR	
		Heart Attack (MI)	Date:
		Chest Pain (Angina)	
		Irregular Heart Rate/Rhythm/Pacemaker	
		High Blood Pressure	
		Bleeding Disorder: (specify)	
		Anticoagulant Treatment	

Cardiologist: ______________________

Anticoagulant Management: ______________________

Y	N	RESPIRATORY
		Shortness of Breath
		Asthma or Wheezing/Inhaler
		Snoring/Sleep Apnea/Difficult Airway
		Emphysema/COPD
		Chronic/Frequent Bronchitis or Pneumonia
		Tuberculosis (TB)

Pulmonologist: ______________________

Y	N	LIFESTYLE		
		Do you smoke?	# years smoked:	# packs per day:
		Former Smoker, year you quit?		
		Do you drink alcohol?		Drinks/week:
		Treated for drug/alcohol dependency?		
		Currently pregnant?		
		Date of your last period:		
		[ ] Menopause [ ] Hysterectomy		

Y	N	SKIN
		Open Wounds/Breaks in Skin
		Rashes
		History of Cold Sores/Shingles/Herpes

Dermatologist: ______________________

Y	N	GASTROINTESTINAL/GENITOURINARY
		Heartburn/GERD/Reflux/Hiatal Hernia
		Kidney Disease: (specify)
		Hepatitis/Liver Function
		Colitis/Other Abdominal Problems

Gastroenterologist: ______________________

Nephrologist: ______________________

Y	N	ENDOCRINE/IMMUNE SYSTEM	
		Diabetic: [ ] Type 1 [ ] Type 2	Avg AM level:
		Thyroid Problems	
		HIV/AIDS	

Endocrinologist: ______________________

Y	N	MUSCLE/SKELETAL
		Osteoporosis
		Use of a Cane/ Wheelchair/Walker

Y	N	OTHER	
		MRSA Infection	Date:
		Cancer/Chemo: (specify)	

Oncologist: ______________________

Y	N	
		Serious problems with any prior anesthetics
		Family history with serious anesthesia problems
		Infection/Illness in past 6 months:
		Current, or Date Resolved:

Other medical problems or comments:

When was your last vaccination/flu shot?

OFFICE USE ONLY

Patient Initials: ____ Date: ____________________ Patient Initials: ____ Date: ____________________

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PREVIOUS TREATMENTS FOR THIS PAIN

PHYSICAL THERAPY

☐ Never Tried ☐ Not Helpful ☐ Minimally Helpful ☐ Somewhat Helpful ☐ Helpful

Where?______________________________ How long/Last Treatment: ____

CHIROPRACTIC CARE

☐ Never Tried ☐ Not Helpful ☐ Minimally Helpful ☐ Somewhat Helpful ☐ Helpful

MASSAGE

☐ Never Tried ☐ Not Helpful ☐ Minimally Helpful ☐ Somewhat Helpful ☐ Helpful

ACUPUNCTURE

☐ Never Tried ☐ Not Helpful ☐ Minimally Helpful ☐ Somewhat Helpful ☐ Helpful

SPINE INJECTIONS

☐ Never Tried ☐ Not Helpful ☐ Minimally Helpful ☐ Somewhat Helpful ☐ Helpful

SPINE SURGERY

☐ Never Tried ☐ Not Helpful ☐ Minimally Helpful ☐ Somewhat Helpful ☐ Helpful

MEDICATIONS/OTC PAIN MEDS

☐ Never Tried ☐ Not Helpful ☐ Minimally Helpful ☐ Somewhat Helpful ☐ Helpful

DIAGNOSTIC IMAGING

MRI Where:___________________________________ Approx Date: ___________________________

CT Where:___________________________________ Approx Date: ___________________________

XRAY Where:___________________________________ Approx Date: ___________________________

MEDICATIONS / PREVIOUS SURGERIES

MEDICATION NAME Please list all current prescription and over-the counter medications.	**SURGERY**	**YEAR**

Preferred Pharmacy: ______________________________ City: _________________________ Phone: ______________

ALLERGIES:

Please list ALL medication allergies

☐ No known drug allergies ☐ Tape/Adhesives ☐ Latex ☐ Iodine/Contrast Dye ☐ Shellfish

Substance	**Reaction**(Itching, rash, breathing difficulties, etc.)

PAIN DIAGRAM

On the diagrams below shade in where you are experiencing pain, right now.

Name:____ DOB:_______________________

Signature:____

PAIN SCALE

Rate the severity of your pain by checking one box on the following scale.

No Pain ... Worst Possible Pain

0	1	2	3	4	5	6	7	8	9	10