



# PIPER SPINE CARE

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## ORTHOPEDIC HISTORY

Name: \_\_\_\_\_ Height/Weight: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Gender: \_\_\_\_\_

Pharmacy Name/Phone: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

### History of Current Problem

Describe Problem: \_\_\_\_\_

When did the problem start? \_\_\_\_\_ How did the problem start? \_\_\_\_\_

Current problem is the result of a (check all that apply):

Car Accident    Work Accident    Sports Injury    Other: \_\_\_\_\_

What tests have you had for this problem?    XRay    MRI    Other: \_\_\_\_\_

What treatments have you had for this problem? \_\_\_\_\_

What type of work do you do? \_\_\_\_\_

### Pain Rating

Are you experiencing pain?    YES    NO   Describe the pain: \_\_\_\_\_

Please circle the number that represents the amount of pain you are having

(No Pain)	0	1	2	3	4	5	6	7	8	9	10	(Worst Pain of Your Life)
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Does it disturb your sleep?    YES    NO

What makes it feel better? \_\_\_\_\_ Worse? \_\_\_\_\_

What are you now unable to do because of this condition? \_\_\_\_\_

### Past Medical History

Condition	Y	N	Condition	Y	N
Sleep Apnea			Diabetes?		
Reflux			Last HbA1c Value? _____		
Taking blood thinner medication?			Anesthetic difficulties?		
High Blood Pressure?			Cancer?		
Coronary artery disease?			Rheumatoid arthritis?		
Congestive Heart Failure?			Blood Clot/ Pulmonary Embolism?		
Asthma?			Osteoporosis?		
COPD?			Gout?		
Hepatitis C?			Kidney disorders?		
HIV?			High Cholesterol?		
Other: _____					

**Current Medications (Name and Dose):**

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**Allergies (Name and Type of Reaction):**

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**Past Surgical History:**

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**Family and Social History:**

Cancer	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Alcohol Use	<input type="checkbox"/> YES	<input type="checkbox"/> NO	drinks/week: _____
Heart Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Smoking	<input type="checkbox"/> YES	<input type="checkbox"/> NO	packs/day: _____
Hypertension	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Drug Use	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Osteoarthritis	<input type="checkbox"/> YES	<input type="checkbox"/> NO				
Other:	_____					

**Review of Systems:**

Systemic Symptoms	Y	N	Pulmonary Symptoms	Y	N
• Weight Change			• Shortness of Breath		
• Chills/Fever			• Cough		
• Night Sweats			• Coughing up Blood		
• Feeling Tired or poorly			• Wheezing		
<b>HEENT Symptoms</b>			<b>Cardiovascular Symptoms</b>		
• Headache			• Chest pain or discomfort		
• Eyesight Problems			• Fast heart rate		
• Nosebleed			• Palpitations		
<b>Genitourinary Symptoms</b>			<b>Gastrointestinal Symptoms</b>		
• Blood in Urine			• Difficulty Swallowing		
• Painful Urination			• Heartburn		
• Increased Urinary Frequency			• Vomiting		
<b>Skin Symptoms</b>			• Abdominal Pain		
• Skin infections			• Diarrhea		
• Skin lesions			<b>Hematological Symptoms</b>		
• Rashes			• Easy bleeding		
<b>Endocrine Symptoms</b>			• Easy bruising tendency		
• Excessive sweating			• Blood clots/Pulmonary Embolism		
• Excessive Thirst			<b>Neurological Symptoms</b>		
• Sleep disturbances			• Dizziness		
<b>Psychological Symptoms</b>			• Vertigo		
• Sleep Disturbances			• Loss of strength		
• Anxiety			• Sensory disturbances		
• Depression			Other _____		

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_