Springfield MEDICAL CENTER, P.C.
Back & Neck Pain . Primary Care . Physical Medicine

Name:_____ Age:_____ Date:_____
BP:_____/_____ P:_____ Height:_____ Weight: _____ **(office use)**

What is the main reason for your visit today? (Please circle)

abdominal pain	chest pain	earache	rib pain	**Pain** (circle)	neck R L	_____
acid reflux	cholesterol	flu	sciatica	arm R L	knee R L	_____
anxiety	cough	fever	sinus	upper back	ankle R L	_____
allergies	depression	headaches	sore throat	mid back	hand R L	_____
asthma	diarrhea	muscle pain	urinary symptoms	lower back	elbow R L	_____
blood pressure	diabetes	pelvic pain		leg R L	foot R L	_____
car accident	dizziness	physical exam		shoulder R L		

Other (or detail above):_____
_____
When did symptoms begin:_____
Where is most of the pain:_____
Does the pain radiate:_____
Describe your symptoms:(ie: burning, constant):_____
Have you received prior treatment for this:_____
What makes it better:_____
What makes it worse:_____
When is it better:_____
When is it worse:_____
Rate the pain (0-10 worst)_____
Other problems today:
1:_____
2:_____
3:_____

Past Medical History: Please Circle

anxiety	depression	heart disease/attack	lung disease
arthritis	diabetes	hepatitis	migraines
asthma	- diet controlled	high blood pressure	neck pain
back pain	- medication	hyperthyroidism	panic attacks
cancer	glaucoma	hypothyroidism	sciatica
car accident	gallbladder	kidney infection	seizure
		kidney stones	stroke or TIA

other (or detail above) _____
no significant past history _____

List your other doctors:

Primary Care:
Gynecologist:

Past Surgical History: What Year?

appendix:	gallbladder:	orthopedic:
bladder repair:	hernia:	sinus:
coronary bypass:	hysterectomy:	tonsillectomy:
other (or detail above)	_____	_____
no significant past history	_____	_____

Other Injuries:

_____ _____ _____
_____ _____ _____

When was your last? Result?

mammogram:
cholesterol:
PSA for prostate:
pap smear:
colonoscopy:
prostate check:
blood in stool:

Current Medications:

Medication	Dose	How Often?
Ex: Advil	**200mg**	**2 as needed**

Do you have any allergies to medications?
If yes, please describe below:

Medication	Reaction
Ex: Penicillin	**Rash**

Review of Systems: Recently have you had any of the following: **(Please circle)**

General
weight change
change appetite
heat/cold intolerance
change in sleep
change stress
Head
severe headaches
dizziness
Skin
new rashes
new lesions

Eyes
vision changes
eye pain
glasses
Ears
hearing changes
ear pain
ringing in ears
Psychiatric
change memory
change thought
change behavior

Nose
discharge
change in smell
bloody noses
sinus pain
Throat
hoarseness
difficulty swallowing
bleeding gums
Extremities
joint pain
joint swelling
joint stiffness
Cardiac
chest pain
palpitations
leg swelling
Neurological
gait disturbance
balance problems
Respiratory
cough
wheezing
shortness of breath

GI
nausea
vomiting
indigestion
diarrhea
constipation
black stools
hemorrhoids
GU
painful urination
frequent urination
blood in urine

other (or detail above) _____ _____
_____ _____

Social History
Occupation:_____
Marital Status: Single_____Married_____Divorced_____Widowed_____
Children/ages:_____
Do you use cigarettes/cigars/chew?(_____packs/_____day;_____years) when did you start?_____Age quit:_____
Do you use alcohol_____(none, occasional, moderate, heavy, binge)
Do you use coffee, tea or caffeine containing beverages (_____cups/day)

Family History
Father:(alive/deceased) age:_____ medical conditions_____
Mother: (alive/deceased) age:_____ medical conditions_____
Brother/Sister (alive/deceased)age:_____medical conditions_____
Brother/Sister (alive/deceased)age:_____ medical conditions_____
Brother/Sister (alive/deceased)age:_____ medical conditions_____
Brother/Sister (alive/deceased)age:_____ medical conditions_____
Additional:_____
Unknown: (adopted)

Signature: _____ Date: _____