New York Center for Spinal Disorders

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NEW PATIENT GENERAL MEDICAL HISTORY

Name:_____ DOB_____/_____/_____ Age:_____

Male/Female Height:_____ Weight:_____ Right or Left Handed

Reason for Office Visit:_____

Duration of Problem/Date of Injury:_____ Is this a work related Injury_____

Is there current/past/intended litigation regarding this injury?_____

Medical History; List all current medications with dosage and frequency

_____

Pharmacy Number #_____

List all allergies to medication: None_____ Penicillin_____Sulfa ___ Other_____

List all Medical Problems you have had in your lifetime:

High Blood Pressure_____ Diabetes_____Thyroid Disease_____
Allergy to Latex_____ Lung Disease_____ Kidney Disease_____
Irregular heart rhythm_____ Seizures _____ Stroke_____
Cancer_____ Osteoporosis_____ HIV/AIDS_____
Coronary Artery Disease_____ Blood Clots_____ Hepatitis A, B or C_____
Prolonged Bleeding_____ Pacemaker_____

SURGICAL HISTORY: List all operations you have had in your lifetime: (include date)

_____

_____

SOCIAL HISTORY: Alcohol_____ per day_____Social Drinker_____

Tobacco Use: Cigar_____ Cigarette_____ Pipe_____ per day

When did you start_____ When did you quit_____

FAMILY HISTORY: Does anyone in your family have (please specify which family member):

Diabetes_____ Heart Disease_____ Cancer_____

Thyroid Disease_____Tuberculosis_____ Other_____

X_____ Date_____
(Patient's Signature or Parent/Guardian Signature for a minor)