MAJOR CHANGES
Rehab Centre
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MEDICAL HISTORY FORM – PAGE 2

Previous Treatments & Tests

Name the doctor that first treated you for this problem

____

Have you seen a spine surgeon in the past? [ ] Yes [ ] No

If Yes, Surgeon's name _______________________________

What treatments did you have? __________________________

____

Test you have had? [ ] CT Scan [ ] MRI [ ] X-Ray [ ] EMG [ ] Other

____

Did you have any injections for your problem? [ ] Yes [ ] No

List: ____

Did these injections help? [ ] Yes [ ] No

If yes, please describe: ______________________________

Did you have any previous back or neck surgery? [ ] Yes [ ] No

If yes, please describe: ______________________________

Please list PREVIOUS SURGERIES and dates: ________________

____

____

Have you ever had a blood transfusion? [ ] Yes [ ] No

If yes, please describe: ______________________________

Have you had physical therapy for your problem? [ ] Yes [ ] No

If yes, please describe: ______________________________

Did this therapy help? [ ] Yes [ ] No

If yes, please describe: ______________________________

Do you do special exercises for your injury? [ ] Yes [ ] No

If yes, please describe: ______________________________

List any medications you are taking? ____________________

____

List other medications you have tried? ___________________

____

What do you hope we can accomplish today? _______________

____

What other concerns do you have? ______________________

____

Your Health

List any allergies that you have ________________________

____

Do you have any adverse reactions to anesthesia? [ ] Yes [ ] No

If yes, please describe: ______________________________

Do you smoke? [ ] Yes [ ] No If Yes, How many packs? ________

Do you drink alcohol? [ ] Yes [ ] No If Yes, How often? ________

Do you have any of the following medical problems?

AIDS / HIV	[ ] Yes [ ] No	Cancer	[ ] Yes [ ] No
Nerve Problems	[ ] Yes [ ] No	Diabetes	[ ] Yes [ ] No
Arthritis / Joint Pain	[ ] Yes [ ] No	Epilepsy	[ ] Yes [ ] No
Stomach Problems	[ ] Yes [ ] No	Hepatitis	[ ] Yes [ ] No
Thyroid Problems	[ ] Yes [ ] No	Anxiety	[ ] Yes [ ] No
Psychiatric Prob.	[ ] Yes [ ] No	High BP	[ ] Yes [ ] No
Depression	[ ] Yes [ ] No	Migraines	[ ] Yes [ ] No
Heart Problems	[ ] Yes [ ] No	Swollen Ankles	[ ] Yes [ ] No
Bleeding Disorders	[ ] Yes [ ] No	Headaches	[ ] Yes [ ] No
Muscle Diseases	[ ] Yes [ ] No		

Recently have you had:

Fever / Chills	[ ] Yes [ ] No	Weight Loss	[ ] Yes [ ] No
Worse Pain at Night	[ ] Yes [ ] No	Chest Pain	[ ] Yes [ ] No
Shortness of Breath	[ ] Yes [ ] No	Night Sweats	[ ] Yes [ ] No

Other Problems ____

Your FAMILY Health History

Back / Neck Prob.	[ ] Yes [ ] No	Hepatitis	[ ] Yes [ ] No
AIDS / HIV	[ ] Yes [ ] No	High BP	[ ] Yes [ ] No
Arthritis / Joint Pain	[ ] Yes [ ] No	Cancer	[ ] Yes [ ] No
Migraines	[ ] Yes [ ] No	Headaches	[ ] Yes [ ] No
Arthritis / Joint Pain	[ ] Yes [ ] No	Diabetes	[ ] Yes [ ] No
Bleeding Disorders	[ ] Yes [ ] No	Epilepsy	[ ] Yes [ ] No
Muscle Diseases	[ ] Yes [ ] No	Heart Prob.	[ ] Yes [ ] No
Psychiatric Prob.	[ ] Yes [ ] No	Nerve Prob.	[ ] Yes [ ] No
Thyroid Problems	[ ] Yes [ ] No	Stomach Prob.	[ ] Yes [ ] No

Other Problems ____

____

Reviewed By: ______________________________ Date: ______________