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Spine Surgery Associates, P. C

Date: ___/___/___ Name: _____

PAST MEDICAL HISTORY:

Tuberculosis	Y	N	Glandular Disorders	Y	N
Diabetes	Y	N	Skin Disease	Y	N
Blood Disease	Y	N	Neurologic Disorders	Y	N
Heart Disease	Y	N	Emotional Disorders	Y	N
Kidney Disease	Y	N	Blood Transfusions	Y	N
High Blood Pressure	Y	N	Pregnancies # _____	Y	N
Liver Disease	Y	N	Ulcer	Y	N
High Cholesterol	Y	N	Other _____	Y	N

PAST SURGICAL HISTORY:

Surgical Procedure	Yr.	Surgeon	Hospital
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any Other hospitalizations? Y N (If Y, please explain by giving dates/names of physicians)
Reason Yr. Physician Hospital

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Cancer History Y N (If Y, please explain type of cancer or location)

FAMILY HISTORY:

	Living	Deceased	Cause of Death	Age
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
Sisters(s)	_____	_____	_____	_____

Please mark the following if found in the family:

	Mother	Father	Sister	Brother
Cancer	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____
Lung Disease	_____	_____	_____	_____
Seizures	_____	_____	_____	_____
Spinal Problems	_____	_____	_____	_____
Stroke	_____	_____	_____	_____

SOCIAL HISTORY:

Activity Limitations: (What you cannot do because of the spinal problem)

Marital Status: Married Single Divorced Separated Widowed
Number of Children: _____ Ages: _____ #living at home: _____
Education Completed(years): 9 10 11 12 13 14 15 16 16+
Alcohol Use: _____ #Beers /drinks per day _____ # Beers / drinks per week
Tobacco Use _____ packs per day # of years _____ Ceased smoking _____ years ago

PLEASE TURN THE PAGE OVER AND COMPLETE

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WORK STATUS: (If Applicable)

Usual Occupation: _____

Current Job If Different from Usual: _____

Employer (Name and Address): _____

1) Are you presently off work due to your injury? Y N

2) Have you been on disability due to this injury? Y N

If so, what is your last day at work: _____

3) Is this a disability examination? Y N

If so, who is the party requiring the exam: _____

3) Is there legal action pending? _____

If so, Attorney's Name and Address: _____

CURRENT MEDICATIONS: (List all current medications not just those for back problems)

Name	Dosage	Physician Name	How long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES:(Specify the name of MEDICATIONS and type of REACTION like Itching, Rash, Hives, Wheezing)

Medications	Type of Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Please list Foods, Pollen, or other environmental factors that effects you:

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REVIEW OF SYSTEMS

Constitutional:

Good general health	Y N
Recent weight change Gain or Loss	Y N
Fever / Chills	Y N

Ophthalmologic:

Glaucoma	Y N
Cataracts	Y N
Wear Glasses / Contact lens	Y N

Cardiovascular:

Heart attack / Congestive heart failure	Y N
Mitral valve prolapse	Y N
Irregular heart rhythm	Y N
Angina	Y N
Pacemaker	Y N
Hypertension	Y N
High Cholesterol	Y N

Respiratory:

Asthma	Y N
Tuberculosis	Y N
Chronic obstructive pulmonary disease / Emphysema	Y N
Shortness of breath	Y N
Chronic cough	Y N
Sleep Apnea	Y N

Gastrointestinal:

Reflux/ GERD (Gastro Esophageal Reflux Disease)	Y N
Hiatal hernia	Y N
Change in bowel habits	Y N
Ulcers	Y N
Hepatitis	Y N
Cirrhosis	Y N

Genitourinary / Renal:

Stones	Y N
Kidney disease	Y N
Dialysis	Y N
Blood in urine	Y N
Change in force when urinating	Y N
Frequency	Y N

Integumentary:

Edema (Swelling in extremities)	Y N
Varicose vein	Y N

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Psychiatric: None

Memory loss or confusion Y N
Anxiety/Depression Y N
Bipolar Y N

Hematologic / Lymphatic: None

Clotting problems Y N
Aspirin use Y N
Non-steroidal anti-inflammatory drug use Y N
Coumadin or Plavix use Y N
Blood Clot Y N
Blood disease Y N
Anemia Y N

Endocrine / Diabetes: None

Thyroid Y N
Steroid use Y N
Non-Insulin Dependent Diabetes Mellitus Y N
Insulin Dependent Diabetes Mellitus Y N

Immunologic: None

HIV Y N
History of Infection Y N
Immuno-Suppression Y N
Autoimmune Disease Y N

Musculo / Skeletal: None

Back pain Y N
Neck pain Y N
Rheumatoid arthritis Y N
Osteoarthritis / Deformities Y N
Difficulty walking Y N

Neurological: None

Headaches / Migraines Y N
Paralysis Y N
Stroke Y N
Weakness Y N
Dizziness Y N
Bowel / Bladder Incontinence Y N

Other:

Please list any other medical conditions that are not listed on this form
