ARIZONA SPINE CONSULTANTS, LTD.
Louis R. Rappoport, M.D.

MEDICAL HISTORY FORM

Patient Name: ____ Today's Date: _____________________

DOB: ____________________________ Age: ________ How did you hear about us? ________________

MAJOR COMPLAINT:

(CIRCLE ALL THAT APPLY)

Neck pain	Middle back pain	Lower back pain
Leg Pain: Right / Left / Bilateral	Foot Pain: Right / Left / Bilateral	Arm Pain: Right / Left / Bilateral
Hand Pain: Right / Left / Bilateral	Headaches	Hand Dominance: Right / Left

Weakness **Numbness or Tingling**

Weakness			Numbness or Tingling	
Upper Extremities: Right / Left / Bilateral	Hand: Right / Left / Bilateral		Upper Extremities: Right / Left / Bilateral	Hand: Right / Left / Bilateral
Lower Extremities: Right / Left / Bilateral	Foot: Right / Left / Bilateral		Lower Extremities: Right / Left / Bilateral	Foot: Right / Left / Bilateral

Bowel dysfunction / Bladder dysfunction: Explain: ____

When did problem start? ___________________ Date of Injury? _____________ Work Related? ______

Lawsuit? Yes / No Prior Similar Injury or Symptoms? Yes / No
Explain:____

WHICH OF THE FOLLOWING AGGRAVATE YOU PAIN? (CIRCLE ALL THAT APPLY)

Coughing	Sneezing	Bearing down	Standing	Sitting	Walking	Driving
Bending	Pulling	Pushing	Positional change	Lifting	Sleeping	Worse in the morning
Worse at the end of the day						

What relieves your pain? ____

LIST ALL PREVIOUS TREATMENT TO INCLUDE:

Physical Therapy – How much? __________________________ When did you go last? _____________
Traction Therapy – Yes / No TENS UNIT? Yes / No
Pain Management: Medication? ____
Injection therapy: Epidural Injection? ____________________How Many? ____________ When? _____
Facet Blocks? ______________________ How Many? _________ When? __________
Nerve Blocks? ______________________ How Many? _________ When? __________

LIST ALL PREVIOUS DIAGNOSTIC TESTING AND DATES: (EX: X-rays, MRI testing, CT scans, Myelograms, Ultrasound…)
____
____
____
____
____

LIST ALL PREVIOUS SURGERIES AND DATES:
____
____
____
____

LIST ALL MEDICATIONS, DOSAGES AND DIRECTIONS: (Include All Medications)
____
____
____
____
____

Pharmacy Name ____
Address or cross streets____
Phone# ____

Please request and bring all previous diagnostic testing films and reports along with any medical records pertaining to your medical condition for review by Dr. Rappoport.

SYMBOLS TO USE

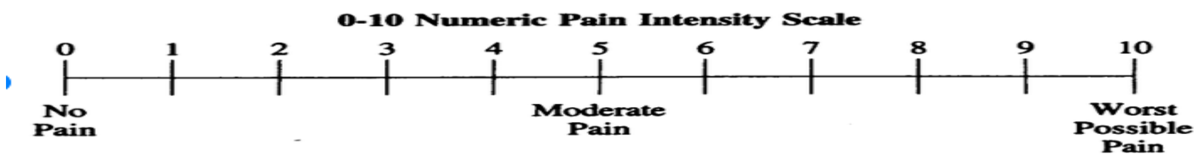
Aching: △△△
Numbness: =====
Pins & Needles: OOO
Burning: XXX
Stabbing: ///
Radiates: →→→

Groin
Mid Back
Low Back
SI (Sacroiliac)
Buttocks
Legs

How bad is your pain now? ____

Please mark with an **"X"** on the body form where the pain is worst now.

Please mark on the line how bad your pain is now:



Do You Have a Signed Narcotics Agreement? Yes ☐ / No☐
Do you have a Marijuana Card? Yes ☐ / No☐
Do you smoke cigarettes (tobacco)? Yes ☐ / No☐ if yes How much? _______ at what age did you start? _________
How many alcohol beverages do you drink daily? _____________________________.

PAST/CURRENT PERSONAL MEDICAL HISTORY: Have YOU EVER had any of the following?

Heart/Lungs
- ☐ Asthma
- ☐ Heart Disease *(valve, vessel, rheumatic, etc.)*
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Pneumonia

Endocrine
- ☐ Adrenal Disorders
- ☐ Diabetes
- ☐ Polycystic Ovary Syndrome (PCOS)
- ☐ Thyroid Disorder

Kidney
- ☐ Chronic Kidney or Bladder Disease
- ☐ Kidney Stones

Ears/Eyes/Nose/Throat
- ☐ Chronic Sinus Infections
- ☐ Eye Disorders *(other than glasses or contacts)*
- ☐ Hearing Loss
- ☐ Nasal Allergies/Hayfever

☐ NO Significant Health Problems

Stomach/Bowel
- ☐ Celiac Disease
- ☐ Irritable Bowel Syndrome
- ☐ Stomach/Duodenal Ulcers
- ☐ Ulcerative Colitis/Crohn's
- ☐ Other Liver, Stomach, or Bowel Disease

Neurological
- ☐ Concussions
- ☐ Convulsions/Seizures
- ☐ Migraines/Severe Headaches
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Stroke/TIA

Mental Health
- ☐ ADHD
- ☐ Alcohol Abuse
- ☐ Anorexia *(Eating Disorder)*
- ☐ Anxiety Disorder
- ☐ Bulimia *(Eating Disorder)*
- ☐ Depression
- ☐ Drug Dependency
- ☐ Other Mental Health Problems

Hematology/Oncology
- ☐ Anemia
- ☐ Bleeding Disorders
- ☐ Blood Clots/Clotting Disorders
- ☐ Cancer
- ☐ Radiation Therapy

Orthopedics
- ☐ Arthritis
- ☐ Fractures/Broken Bones

Infectious Diseases
- ☐ Chickenpox/Varicella
- ☐ Hepatitis Type: ______
- ☐ HIV Infection
- ☐ Infectious Mononucleosis
- ☐ Malaria
- ☐ Mumps
- ☐ Tuberculosis
- ☐ Typhoid Fever

Skin
- ☐ Eczema
- ☐ Psoriasis
- ☐ Hives

STDs
- ☐ Chlamydia
- ☐ Genital Herpes
- ☐ Genital Warts
- ☐ Gonorrhea
- ☐ HPV
- ☐ Other STD

Surgical History
- ☐ Appendectomy
- ☐ Adenoidectomy
- ☐ Ear Tubes
- ☐ Gallbladder Removal
- ☐ Knee ACL Repair L ___ R ___
- ☐ Knee Arthroscopy L ___ R ___
- ☐ Organ Transplant
- ☐ Ovarian Cyst Removal
- ☐ Splenectomy
- ☐ Tonsillectomy
- ☐ Weight Loss Surgery
- ☐ Other Prior Surgeries ______

Social History
- ☐ Do you drink alcohol?
- ☐ Do you exercise regularly?
- ☐ Do you take recreational drugs?

OB/GYN History
- ☐ Endometriosis
- ☐ Pregnancies #: ____

Exercise History
- ☐ Lack of exercise
- ☐ Exercising regularly

Moderate Exercising
Walking briskly, water aerobics, etc.
- ☐ Less than 3 times per week
- ☐ 3 or more times per week

Strenuous Exercising
Running, swimming laps, etc.
- ☐ Less than 3 times per week
- ☐ 3 or more times per week

Be prepared to inform the nurse of current medications *(include birth control, acne, over the counter medications, vitamins, etc.)*

Allergies

Have you ever had an allergic reaction? ☐ Yes ☐ No

Medication Allergies: ______

Food Allergies: ______

Other Allergies (latex, beestings, etc.): ______

Other History
- ☐ Previous Hospitalizations ______
- ☐ OTHER Health Problems ______

Does YOUR IMMEDIATE FAMILY have any of the following? ☐ Adopted (Family history unknown)

		Mother	Father	Siblings	Grandparents
Alcoholism					
Blood Clots/Clotting Disorders					
Cancer	Breast				
	Colon				
	Melanoma				
	Other Cancers (List Type)				
Diabetes					
Drug Dependency					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Mental Illness					
Stroke					
Sudden Cardiac Arrest (under age 50)					
Other (Please explain)					
Parent Deceased					