PATIENT HISTORY FORM

Date of Visit: ___________________________

☐ **Steven E. Levine, MD**

PATIENT DEMOGRAPHIC INFORMATION

Name: ____
Last | First | Middle Initial

____
Home Address | City / State | Zip

(______) ______________________ (______) ______________________ __________________________
Home Phone | Cell Phone | Email Address

Date of Birth: _____/_____/_____ **Social Security Number:** _________-_______-_________

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed

Primary Care Physician: ___________________________________ **Phone**: (_____) _______________

EMERGENCY CONTACT INFORMATION

Contact Person: ____ **Phone:** (_____) _______________

Relationship: ____

May we release your Personal Health Information to this person? ❒ Yes ❒ No

REFERRAL INFORMATION

How were you referred to our office?

❒ Primary Care Physician ❒ Patient ❒ Internet ❒ Phone Book ❒ Advertisement

❒ Other Provider Name: ___________________________________ **Phone:** (_____) _______________

CONDITION INFORMATION

Chief Complaint: ____

____

When did you start experiencing these symptoms? _______________________________________

PREVIOUS DIAGNOSTIC TESTING

What types of diagnostic testing have you had for this condition?

Type of Test:	Date of Test:	Location of test:
❒ No Previous Testing		
MRI		
C/T Scan		
X-rays		
EMG		
Pet Scan		

PERSONAL MEDICAL HISTORY

Are you being treated for or been diagnosed with had any of the following medical conditions? (Check applicable boxes below)

EENT

❒ Blindness
❒ Cataracts
❒ Contacts
❒ Deaf
❒ Glaucoma
❒ Hearing Aids
❒ Hearing Loss
❒ Nose Bleeds
❒ Season Allergies
❒ Sinusitis
❒ Swallowing Problems

Cardiovascular

❒ Angina / CAD
❒ Arrhythmia
❒ Atrial Fibrillation
❒ Blood Vessel Blockage
❒ Congestive Heart Failure
❒ DVT
❒ Heart Murmur
❒ Hypotension (Low Blood Pressure)
❒ Hypertension (High Blood pressure)
❒ Pacemaker
❒ Peripheral Vascular Disease
❒ Rheumatic Fever
❒ Stent
❒ Valve Replacement Surgery
❒ Other

____

Gastrointestinal

❒ Cirrhosis
❒ Gallstones
❒ GERD
❒ Hernia
❒ IBS
❒ Pancreatitis
❒ Ulcers

Genitourinary

❒ Hysterectomy
❒ Kidney Stones
❒ Renal Failure
❒ Renal Insufficiency
❒ Sexual Dysfunction
❒ Tubal Ligation

Endocrine

❒ Diabetes
❒ Hyperthyroid
❒ Hypothyroid
❒ Menstrual Irregularity
❒ Obesity
❒ Thyroid Disorder

Hematologic

❒ Anemia
❒ Bleeding Disorder

Transmissible

❒ TB
❒ Recent TB Exposure
❒ + TB Test

Neurological

❒ Alzheimer's
❒ Aneurysm
❒ Epilepsy / Seizures
❒ Headaches
❒ Head Injury
❒ Migraines
❒ Multiple Sclerosis
❒ Parkinson's Disease
❒ Peripheral Neuropathy
❒ Stroke

Psychological

❒ ADD / ADHD
❒ Anxiety
❒ Bi-polar Disorder
❒ Dementia
❒ Depression
❒ Schizophrenia

Respiratory

❒ Asthma
❒ COPD
❒ Diabetes: Type 1 *or* Type 2
❒ Emphysema
❒ Sleep Apnea

Cancer

❒ Bone Cancer
❒ Breast Cancer
❒ Colon Cancer
❒ Lung Cancer
❒ Melanoma
❒ Prostate Cancer
Other:
❒ _________________

Musculoskeletal

❒ Back Pain
❒ Broken Bones
❒ Connective Tissue Disorder
❒ Decrease in Muscle Size
❒ Fibromyalgia
❒ Kyphoscoliosis
❒ Muscular Disorder
❒ Neck Pain
❒ Osteoarthritis
❒ Rheumatoid Arthritis
❒ Scoliosis

Disease

❒ Hepatitis A
❒ Hepatitis B
❒ Hepatitis C
❒ HIV+
❒ AIDS
❒ Shingles

SURGICAL HISTORY

Please check any box listed below pertaining to your surgical history:

❒ No Surgical Procedures

General Surgery

❒ Appendectomy (Year:_______)

❒ Cholecystectomy (Year:_______)

❒ Gastric Bypass (Year:_______)

❒ Hernia Surgery (Year:_______)

Heart Procedure

❒ AICD (Year:_______)

❒ CABG (Year:_______)

❒ Cardiac Catheterization(Year:_______)

❒ Coronary Stents (Year:_______)

❒ Heart Valve Replacement (Year:_______)

❒ Permanent Pacemaker (Year:_______)

❒ Angioplasty (Year:_______)

❒ Ablation (Year:_______)

Gynecology

❒ C-Section (Year:_______)

❒ Hysterectomy (Year:_______)

❒ Tubal Ligation (Year:_______)

Other Surgeries

❒ Cataract Surgery (Year:_______)

❒ Kidney Transplant (Year:_______)

Other 1: ______________________

(Year:_______)

Other 2: : ______________________

(Year:_______)

Other 3: : ______________________

(Year:_______)

Other 4: : ______________________

(Year:_______)

Orthopedic

❒ Knee Replacement (Year:____)

↳(Circle one) Right Left Both

❒ Hip Replacement (Year:____)

↳(Circle one) Right Left Both

❒ Carpel Tunnel Surgery (Year:____)

↳(Circle one) Right Left Both

❒ Thoracic Laminectomy (Year:_______)

❒ Cervical Laminectomy (Year:_______)

❒ Lumbar Laminectomy (Year:_______)

❒ Thoracic Spine Fusion (Year:_______)

↳ Spine Levels: ______________________

❒ Cervical Spine Fusion (Year:_______)

↳ Spine Levels: ______________________

❒ Lumbar Spine Fusion (Year:_______)

↳ Spine Levels______________________

❒ Shoulder Surgery (Year:_______)

↳(Circle one) Right Left Both

PRIOR TREATMENTS

Please check any box listed below pertaining to your previous treatment history:

Type of Treatment	Helpful	Not Helpful	Dates of Treatment
Physical Therapy	❒	❒	
Traction Unit	❒	❒	
Chiropractic	❒	❒	
Back Brace	❒	❒	
TENS Unit	❒	❒	
Muscle Stimulator	❒	❒	
Epidural Steroid Injection	❒	❒	
Facet Joint Injection / Medial Branch Block	❒	❒	
Radiofrequency Ablation	❒	❒	
Trigger Point Injections	❒	❒	
Sacroiliac Joint Injections	❒	❒	
Nerve Blocks	❒	❒	
Spinal Cord Stimulator	❒	❒	
Intrathecal Pump	❒	❒	
Kadian	❒	❒	

PRIOR MEDICATIONS

Please check the applicable boxes listed below, pertaining to any medications you may have taken in the PAST (This section does not pertain to medications you are currently taking)

Medication Type / Name	Helpful	Not Helpful	Side Effects (If any)
Steroids			
Steroids (Oral)	❒	❒	
Steroids (Intramuscular-Injected)	❒	❒	
NSAID's			
Acetaminophen (Tylenol)	❒	❒	
Aspirin	❒	❒	
Celecoxib (Celebrex)	❒	❒	
Diclofenac (Voltaren-Oral)	❒	❒	
Flector Patch	❒	❒	
Ibuprofen (Advil, Motrin)	❒	❒	
Lodine	❒	❒	
Meloxicam (Mobic)	❒	❒	
Nabumetone (Relafen)	❒	❒	
Naproxen (Aleve)	❒	❒	
Zipsor	❒	❒	
Muscle Relaxants			
Baclofen	❒	❒	
Carisoprodol (Soma)	❒	❒	
Cyclobenzaprine (Flexeril)	❒	❒	
Diazepam (Valium)	❒	❒	
Metaxalone (Skelaxin)	❒	❒	
Methocarbamol (Robaxin)	❒	❒	
Tizanidine (Zanaflex)	❒	❒	
Short Acting Opioids			
Acetaminophen/Oxycodone (Percocet, Roxicet)	❒	❒	
Codeine/ Acetaminophen (Tylenol 3)	❒	❒	
Fentanyl (Actiq, Sublimaze, Subsys, Fentora)	❒	❒	
Hydrocodone (Lortab, Norco)	❒	❒	
Hydromorphone (Dilaudid)	❒	❒	
Morphine (MSIR)	❒	❒	
Oxycodone (Percocet, Roxicet, Roxicodone)	❒	❒	
Tramadol (Ultram)	❒	❒	
Tapentadol (Nucynta)	❒	❒	
Long Acting Opioids			
Avinza	❒	❒	
Buprenorphine (Butrans, Suboxone)	❒	❒	
Buprenorphine Patch	❒	❒	
Embeda	❒	❒	
Fentanyl Patch (Duragesic)	❒	❒	
Hydromorphone (Exalgo)	❒	❒	

PRIOR MEDICATIONS (Continued)

Please check the applicable boxes listed below, pertaining to any medications you may have taken in the PAST (This section does not pertain to medications you are currently taking)

Medication Type / Name	Helpful	Not Helpful	Side Effects (If applicable):
Long Acting Opioids *Cont'd*			
Methadone (Symoron, Dolophine)	❒	❒	
Morphine (MS Contin)	❒	❒	
Oxycontin	❒	❒	
Oxymorphone (Opana)	❒	❒	
Anti-Neuropathic Agents			
Duloxetine (Cymbalta, Ariclaim)	❒	❒	
Gabapentin-IR (Neurontin)	❒	❒	
Gabapentin-Flow Release (Gralise)	❒	❒	
Milnacipran HCI (Savella, Dalcipran)	❒	❒	
Pregabalin (Lyrica)	❒	❒	
Topiramate (Topamax)	❒	❒	
Anti-Depressants			
Amitriptyline (Elavil)	❒	❒	
Bupropion (Wellbutrin)	❒	❒	
Citalopram (Celexa)	❒	❒	
Duloxetine (Cymbalta)	❒	❒	
Escitalopram (Lexapro)	❒	❒	
Fluoxetine (Prozac)	❒	❒	
Milnacipran (Savella)	❒	❒	
Nortryptyline (Aventyl, Pamelor)	❒	❒	
Paroxetine (Paxil)	❒	❒	
Sertraline (Zoloft)	❒	❒	
Trazadone (Desyrel)	❒	❒	
Venlafaxine (Effexor)	❒	❒	
Sleep Agents			
Ambien	❒	❒	
Lunesta	❒	❒	
Compound Medications			
Baclofen	❒	❒	
BioFreeze	❒	❒	
Bupivacane	❒	❒	
Capsaicin (Capsaicin Cream, Qutenza)	❒	❒	
Cyclobenzaprine	❒	❒	
Diclofenac	❒	❒	
Gabapentin	❒	❒	
Ketamine	❒	❒	
Ketoroiac	❒	❒	
Lidocaine	❒	❒	
Pain Cream	❒	❒	

SOCIAL HISTORY

Please check the applicable boxes listed below pertaining to your social history:

Tobacco Use	Occupation	Sleep Habits
❒ Current every day smoker ❒ Current some day smoker ❒ Former smoker ❒ Never Smoker Date/Year Quit: ______________ # Packs smoked per day: ______ # Years of Habit:	❒ Retired ❒ Disabled ❒ Unemployed ❒ Self-Employed ❒ Employed (Part-time) ❒ Employed (Full-time) ❒ Student ❒ Homemaker	❒ Poor ❒ Fair ❒ Good **Stress Level** ❒ Low ❒ Medium ❒ High
Alcohol Use	**Ability to Care for Self**	**Exercise Habits**
❒ None ❒ Rarely ❒ Socially ❒ Daily ❒ History of Alcohol Abuse	❒ Yes, I'm able to care for myself ❒ No, I'm unable to care for myself Details: ______________________ ______________________________	❒ Never ❒ Rarely ❒ Frequently ❒ Daily

Drug Use

❒ Denies All	Current User	Past User
Amphetamines	❒	❒
Marijuana	❒	❒
Cocaine	❒	❒
Heroin	❒	❒
Other:		

Diet

❒ Poor
❒ Fair
❒ Good

FAMILY HISTORY

Please check any box listed below pertaining to your immediate family's medical history:

Father	Mother	Brother(s)	Sister(s)
❒ Unkown	❒ Unkown	❒ Unkown	❒ Unkown
❒ Arthritis	❒ Arthritis	❒ Arthritis	❒ Arthritis
❒ Asthma	❒ Asthma	❒ Asthma	❒ Asthma
❒ Back / Neck Pain	❒ Back / Neck Pain	❒ Back / Neck Pain	❒ Back / Neck Pain
❒ Bleeding Disorder	❒ Bleeding Disorder	❒ Bleeding Disorder	❒ Bleeding Disorder
❒ Cancer	❒ Cancer	❒ Cancer	❒ Cancer
❒ COPD	❒ COPD	❒ COPD	❒ COPD
❒ Heart Disease	❒ Heart Disease	❒ Heart Disease	❒ Heart Disease
❒ Connective Tissue Disease	❒ Connective Tissue Disease	❒ Connective Tissue Disease	❒ Connective Tissue Disease
❒ Diabetes	❒ Diabetes	❒ Diabetes	❒ Diabetes
❒ Sinusitis	❒ Sinusitis	❒ Sinusitis	❒ Sinusitis
❒ Epilepsy	❒ Epilepsy	❒ Epilepsy	❒ Epilepsy
❒ Hypertension	❒ Hypertension	❒ Hypertension	❒ Hypertension
❒ IBS	❒ IBS	❒ IBS	❒ IBS
❒ Kidney Disease	❒ Kidney Disease	❒ Kidney Disease	❒ Kidney Disease
❒ Mental Illness	❒ Mental Illness	❒ Mental Illness	❒ Mental Illness
❒ Muscular Disorder	❒ Muscular Disorder	❒ Muscular Disorder	❒ Muscular Disorder
❒ Lung Disease	❒ Lung Disease	❒ Lung Disease	❒ Lung Disease
❒ Osteoporosis	❒ Osteoporosis	❒ Osteoporosis	❒ Osteoporosis
❒ Stroke	❒ Stroke	❒ Stroke	❒ Stroke
❒ Tuberculosis (TB)	❒ Tuberculosis (TB)	❒ Tuberculosis (TB)	❒ Tuberculosis (TB)
❒ Thyroid Disorder	❒ Thyroid Disorder	❒ Thyroid Disorder	❒ Thyroid Disorder

ALLERGIES

List any allergies below, including your reactions *(Ex: Shortness of breath, hives, itching, etc.)*:

Allergic to:		Reaction Type:
❒ ***No Known Drug Allergies***	→	
	→	
	→	
	→	
	→	
	→	
	→	
	→	
	→	
	→	
	→	
	→	
	→	

CURRENT MEDICATION LIST

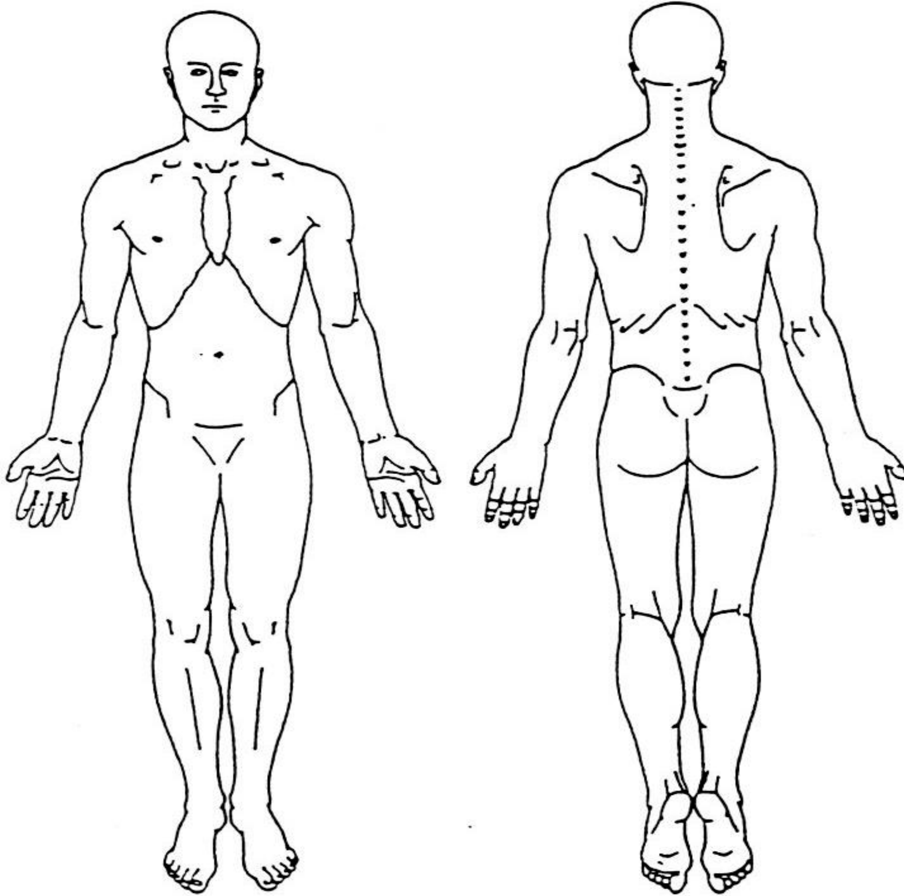
List all medication(s) you are currently taking, including the strength, dose and frequency.

If you take any of the following vitamins: Omega 3 (Fish Oil), Vitamin E, Vitamin D, please include them on the list below.

Medication Name	Strength	Quantity / Dose	Frequency Taken
			Every hrs.
			Every hrs.
			Every hrs.
			Every hrs.
			Every hrs.
			Every hrs.
			Every hrs.
			Every hrs.
			Every hrs.
			Every hrs.
			Every hrs.
			Every hrs.
			Every hrs.
			Every hrs.
			Every hrs.
			Every hrs.
			Every hrs.
			Every hrs.
			Every hrs.
			Every hrs.

PAIN DIAGRAM

On the diagram below shade the area where you are currently experiencing pain that our provider is treating you for:



Please circle the number below that best rates your current pain level

0	1	2	3	4	5	6	7	8	9	10
no pain		little		moderate		quite bad		severe		unbearable pain

REVIEW OF SYSTEMS

Please review the symptoms below and check any "Yes" boxes that apply to you now:

☐ I have not experienced any of the symptoms listed below.

General	Yes	Gastrointestinal	Yes
Weight Loss	☐	Abdominal Pain	☐
Weight Gain	☐	Blood in Stool	☐
Fever	☐	Vomiting	☐
Fatigue	☐	Diarrhea	☐
HEENT	**Yes**	**Urinary**	**Yes**
Blurred Vision	☐	Frequency	☐
Discharge	☐	Hesitancy	☐
Ear Ringing	☐	Flank Pain	☐
Hoarseness	☐	Painful Urination	☐
Light Sensitivity	☐	Blood in Urine	☐
Nose Bleeds	☐		
Pain	☐	**Neurologic**	**Yes**
Sore Throat	☐	Headache	☐
		Confusion	☐
Respiratory	**Yes**	Numbness	☐
Wheezing	☐	Slurred Speech	☐
Cough	☐	Weakness	☐
Shortness of Breath	☐		
		Endocrine	**Yes**
Cardiovascular	**Yes**	Excess Sweat	☐
Chest Pain	☐	Excess Thirst	☐
Fainting	☐	Excess Hot	☐
Feet Swelling	☐	Excess Cold	☐
Palpitations	☐		
		Blood/Lymphatic	**Yes**
Skin/Breast	**Yes**	Bleeding Tendencies	☐
Rash	☐	Lymph Node Swelling	☐
Itching	☐	Easy Bruising	☐
Soreness	☐		
Abscess	☐	**Psychological**	**Yes**
		Anxiety	☐
Musculoskeletal	**Yes**	Depression	☐
Joint Swelling	☐	Severe Stress	☐
Joint Redness	☐	Panic Attacks	☐
Joint Pain	☐		
Muscle Pain/Soreness	☐		
Gait Problems	☐		

Patient Signature ______________________________ Date: _____/_____/_____