MIDWEST PAIN & SPINE

Date of Visit: _____

Provider: ☐ **Phillip R. Kingma, MD**
☐ **Allison L. Bauer, FNP-C**

PATIENT HISTORY FORM

DEMOGRAPHIC INFORMATION

Name: _____
Last **First** **Middle Initial**

_____
Home Address **City / State** **Zip**

(_____) _____ (_____) _____ _____
Home Phone **Mobile Phone** **Email Address**

May we send you automated appointment reminders via mobile and email? ❒ Yes ❒ No

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

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed

EMERGENCY CONTACT INFORMATION

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

Relationship to Patient: _____

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

Can your Emergency Contact pick up your prescriptions? ❒ Yes ❒ No

CARE TEAM INFORMATION

How did you hear about us? ❒ Primary Care Physician ❒ Patient ❒ Internet ❒ _____

❒ **Primary Care Physician:** _____ **Phone**: (_____) _____

❒ **Referring Provider Name**: _____ **Phone:** (_____) _____

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

PATIENT HISTORY FORM COMPLETED ONLINE

❒ COMPLETED ONLINE ❒ COMPLETED W/OUR STAFF _____STAFF INITIALS

Patient Signature _____ **Date:** _____/_____/_____

ALLERGIES

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

I am allergic to:		The reaction it causes:
❒ **No Known Drug Allergies**		
	→	
	→	
	→	
	→	

CHIEF COMPLAINT(S)

Chief Complaint(s)	Right Side	Left Side	Both Sides	Year Started
Ankle Pain	❒	❒	❒	
Arm Pain	❒	❒	❒	
Back Pain	❒	❒	❒	
Buttock Pain	❒	❒	❒	
Cervical (Upper Back) Pain	❒	❒	❒	
Depression	❒	❒	❒	
Fatigue	❒	❒	❒	
Fibromyalgia	❒	❒	❒	
Foot Pain	❒	❒	❒	
General Pain	❒	❒	❒	
Generalized Chronic Pain	❒	❒	❒	
Hand Pain	❒	❒	❒	
Headaches	❒	❒	❒	
Hip Pain	❒	❒	❒	
Joint Pain	❒	❒	❒	
Knee Pain	❒	❒	❒	
Leg Pain	❒	❒	❒	
Lumbar (Low Back) Pain	❒	❒	❒	
Muscle Pain	❒	❒	❒	
Neck Pain	❒	❒	❒	
Pelvic Pain	❒	❒	❒	
Shoulder Pain	❒	❒	❒	
Sleep Problems	❒	❒	❒	
Thoracic (Mid Back) Pain	❒	❒	❒	

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 Pain	❒ Back Pain	❒ Back Pain	❒ Back 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
❒ 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
❒ Neck Pain	❒ Neck Pain	❒ Neck Pain	❒ Neck Pain
❒ 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

SOCIAL HISTORY

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

I have Advanced Directives ❒ Yes or ❒ No
I have a Medical Power of Attorney ❒ Yes or ❒ No

Tobacco Use

❒ Never a Smoker

❒ Current smoker

❒ Former smoker

Year Quit_____

Years of Use: _____

Packs smoke per day: _____

e-Cigarette /Vape:
❒ Yes or ❒ No

Chewing Tobacco Use:
❒ Yes or ❒ No

Ability to Care for Self

Choose One:

❒ I live alone

❒ I live with others

Caring for yourself:

❒ I can care for myself

❒ I am NOT able to care for myself

❒ I have difficulty dressing or bathing myself

❒ I have difficulty walking or climbing stairs

Stress Level

❒ Low
❒ Medium
❒ High

Exercise Habits

❒ Never

❒ Occasional

❒ Moderate

❒ Heavy

Diet

❒ Regular Diet

❒ Other Diet _____

Alcohol Use

❒ None
❒ Occasional
❒ Moderate
❒ Heavy
❒ History of Alcohol Abuse

Drug Use

	Current User	Former User
Amphetamines	❒	❒
Marijuana	❒	❒
Cocaine	❒	❒
Heroin	❒	❒

❒ I only take drugs prescribed by my physician.

Occupation

Employed? ❒ Yes or ❒ No
If Yes, Occupation

_____

❒ Disabled
❒ Homemaker
❒ Retired

Work Related Injury?
❒ Yes or ❒ No

Auto Related Injury?
❒ Yes or ❒ No

Sleep Habits

Do you have difficulty Sleeping?

❒ Yes or ❒ No

PAST MEDICAL HISTORY

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

EENT

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

Cardiovascular

- ❒ Angina / CAD
- ❒ Arrhythmia
- ❒ Atrial Fibrillation
- ❒ Blood Vessel Blockage
- ❒ Congestive Heart Failure
- ❒ Deep Vein Thrombosis
- ❒ Heart Murmur
- ❒ Heart Surgery
- ❒ Hypotension – Low BP
- ❒ Hypertension - High BP
- ❒ Hyperlipidemia
- ❒ Implantable Defibrillator
- ❒ Irregular Heartbeat
- ❒ Myocardial Infarction (MI)
- ❒ Mitral Valve Prolapse
- ❒ Pacemaker
- ❒ Peripheral Vascular Disease
- ❒ Rheumatic Fever
- ❒ Stent
- ❒ Valve Replacement Sx
- ❒ Other _____

Gastrointestinal

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

Genitourinary

- ❒ Frequent Urination
- ❒ Hysterectomy
- ❒ Kidney Stones
- ❒ Renal Failure
- ❒ Renal Insufficiency
- ❒ Sexual Dysfunction
- ❒ Tubal Ligation

Endocrine

- ❒ Diabetes: if yes,
  - ❒Type 1, *or*
  - ❒Type 2
- ❒ Hyperthyroid
- ❒ Hypothyroid
- ❒ Menstrual Irregularity
- ❒ Obesity
- ❒ Thyroid Disorder

Disease

- ❒ Hepatitis A, B or C
- ❒ HIV+/AIDS
- ❒ Shingles TB
- ❒ Recent TB Exposure
- ❒ Positive TB

Neurological

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

Psychological

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

Respiratory

- ❒ Asthma
- ❒ COPD
- ❒ Emphysema
- ❒ Sleep Apnea
- ❒ Shortness of Breath

Hematologic

- ❒ Anemia
- ❒ Bleeding Disorder

Cancer

- ❒ Bone Cancer
- ❒ Breast Cancer
- ❒ Colon Cancer
- ❒ Lung Cancer
- ❒ Skin Cancer
- ❒ Prostate
- ❒ Other

_____

Musculoskeletal

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

SURGICAL HISTORY

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

❒ **No Past Surgical History**

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

❒ Kidney Transplant (Year:_____)

Other 1: _____ (Year:_____)

Other 2: _____ (Year:_____)

Other 3: _____ (Year:_____)

Other 4: _____ (Year:_____)

Musculoskeletal

❒ 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 Pain Pump	❒	❒	
Kadian	❒	❒	

CURRENT MEDICATION LIST

List all medication(s) you are currently taking, including the strength, dose, and frequency.
Include Over the Counter (OTC) Medications, and Vitamins (Ex: Omega 3/Fish Oil, Vitamin E, Vitamin D)

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.

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	☐	Panic Attacks	☐
Joint Redness	☐	Severe Stress	☐
Muscle Pain/Soreness	☐	Bipolar Disorder	☐
Gait Problems	☐	Schizophrenia	☐

FALL RISK ASSESSMENT

Below are questions related to how concerned you are about the possibility of falling.

Please answer thinking about how you usually do the activity. Think about how you usually do the activity listed below. If you currently do not do the activity, please answer to show how concerned you would be about falling **IF** you did the activity.

	ACTIVITY	No Concern	Somewhat Concerned	Fairly Concerned	Very Concerned
1.	**Getting dressed or undressed**	1	2	3	4
2.	**Taking a shower or bath**	1	2	3	4
3.	**Getting in or out of a chair**	1	2	3	4
4.	**Going up or down stairs**	1	2	3	4
5.	**Reaching for something above your head or on the ground**	1	2	3	4
6.	**Walking up or down a slope**	1	2	3	4
7.	**Going out to a social event (religious service, family gathering, club meeting)**	1	2	3	4
	Total				

Adapted from the Prevention of Falls Network Europe, Falls Efficacy Scale International Kempen GIJM, Yardley L. Haastregt JCM van, Zijlstra GAR, Beyer N, Hauer K, Todd

Total Score to be added to Fall Risk Assessment in patient chart