CARDINAL NEUROSURGERY & SPINE, INC.

Daniel L. Kitchens, M.D., F.A.C.S.

NAME: _____ **Date:** _____

Date of Birth: _____ **Date of Last Physical Exam:** _____ **Family MD:** _____ [ ] None
What is the reason for your visit: [ ] Neck [ ] Back [ ] Carpal Tunnel [ ] Ulnar Nerve [ ] Brain
Referred by: [ ] Self [ ] Friend/Family Member [ ] Insurance [ ] Provider:

ALLERGIES List Below▼

_____
_____
_____
_____
_____

Latex Allergy Y/N
[ ] NO KNOWN Drug Allergies but have **ENVIROMENTAL** Allergies i.e. pollen, dust, mold_____

MEDICATIONS PRESCRIPTION, OVER THE COUNTER, VITAMINS, HERBS, ETC...
▼ Please include drug, frequency, reason used and prescribing doctor. ▼ Write in margin if additional space required ▶

_____
_____
_____
_____
_____

[ ] Medication for this condition (muscle relaxers, anti- inflammatory, pain meds listed on Pain Chart

PHARMACY: **Phone No:**

HEALTH HISTORY

Place a check by conditions you have been diagnosed with or have received treatment for

GENERAL
__ Chills
__ Depression
__ Dizziness
__ Fainting
__ Fever
__ Forgetfulness
__ Headache
__ Loss of Sleep
__ Loss of Weight
__ Nervousness
__ Numbness
__ Sweats

MUSCLE/JOINT/BONE
__ Neck __ Back
__ Shoulders __ Hips
__ Arms __ Legs
__ Elbows __ Knees
__ Wrists __ Ankles
__ Hands __ Feet
__ Fingers __ Toes

GENITO-URINARY
__ Blood in urine
__ Frequent urination
__ Lack of bladder control
__ Painful urination

GASTROINTESTINAL
__ Appetite Poor
__ Bloating
__ Bowel Changes
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Hemorrhoids
__ Indigestion or Gas
__ Nausea
__ Rectal Bleeding
__ Stomach Pain
__ Vomiting
__ Vomiting Blood

CARDIOVASCULAR
__ Chest Pain
__ Irregular Heart Beat
__ Rapid Heart Beat
__ High Blood Pressure
__ Low Blood Pressure
__ Poor Circulation
__ Valve problem/replacement
__ Varicose Veins
__ Swelling of Ankles
Stent ___ Pacemaker ___

EYES/EARS/NOSE/THROAT
__ Blurred Vision
__ Double Vision
__ Vision Flashes/Halos
__ Crossed Eyes
__ Earache
__ Ear Discharge
__ Ringing in Ears
__ Loss of Hearing
__ Sinus Problems
__ Hay Fever
__ Nosebleeds
__ Bleeding Gums
__ Difficulty Swallowing
__ Hoarseness
__ Persistent Cough

SKIN
__ Bruise Easily
__ Hives
__ Itching
__ Rash
__ Change in Moles
__ Sores that won't heal
__ Scars
__ MRSA

OTHER:

EDUCATION
Highest Level of Education _____
[ ] Dyslexia
[ ] Attention Deficit Disorder
[ ] Require assistance with reading/writing
[ ] _____

[ ] RIGHT [ ] LEFT Handed
[ ] Ambidextrous

HEALTH HABITS
Check which substances you use and frequency
__ CAFFEINE
(Coffee, tea, soda, etc)
Cups per day _____
__ TOBACCO
Smoke ____ packs/day
__ Vaping with nicotine
Chew _____
__ Alcohol
_____ Drinks per _____
__ Recreational Drugs
Include Frequency of Use
_____

MEDICAL CONDITIONS

Place a check by conditions you have been diagnosed with or have received treatment for

__ Alcoholism
__ Allergy to LATEX
__ Anemia
__ Aneurysm
__ Anorexia
__ Appendicitis
__ Arthritis
__ Asthma
__ Bleeding Disorders
__ Blood Thinners
__ ASA __ 81 __325
__ Plavix __Coumadin
__ _____
__ Breast Lump
__ Bronchitis
__ Bulimia
__ Cancer
__ Cataracts
__ Chemical Dependency
__ Claustrophobia
__ Chicken Pox
__ Diabetes
Last A1C level _____
__ Emphysema
__ Epilepsy
__ Fibromyalgia
__ Glaucoma
__ Goiter
__ Gonorrhea
__ Gout
__ Heart Disease
__ Hepatitis
__ Hernia
__ Herpes
__ High Cholesterol
__ Kidney Disease
__ Liver Disease
__ Measles
__ Migraine Headache
__ Mononucleosis
__ Multiple Sclerosis
__ Mumps
__ Osteoporosis
__ Fosamax __ Boniva
__ Actonel
__ _____
__ Pacemaker __AICD
__ Pneumonia
__ Polio
__ Prostate Problems
__ Psychiatric Care
__ Rheumatic Fever
__ Scarlet Fever
__ Seizures
__ Sleep Apnea
___ CPAP __ Oxygen
__ Stroke __ TIA
__ Suicide Attempt
__ Thyroid Problems
__ Tonsillitis
__ Tuberculosis
__ Typhoid Fever
__ Ulcers
__ MRSA
__ VRE
__ AIDS
__ HIV POSITIVE
__ _____

CONTINUED ON BACK ⟶

Continued from page 1 Use margins if additional space required

MEN COMPLETE THIS SECTION

Have you had the following

__ Breast Lump
__ Lump in Testicles
__ Erection Difficulties
__ Penis Discharge
__ Sore/Lesion on Penis
__ Other

WOMEN COMPLETE THIS SECTION

Are you Pregnant? [ ] Yes [ ] No
Date of last menstrual period _____
Date of last Pap Smear _____

Number Of Pregnancies_____ Number of Children _____

Sex of Birth (Male/Female)	Your Age at Child's Birth	Complications

Have you had the following

__ Breast Lump
__ Nipple Discharge
__ Other
__ Painful Intercourse
__ Vaginal Discharge
__ Abnormal Pap Smear
__ Bleeding Between Periods
__ Extreme Menstrual Pain
__ Hot Flashes

HOSPITALIZATIONS, SERIOUS ILLNESSES, and MEDICAL TREATMENTS

• Please complete to the best of your knowledge • **If left blank you are healthy and have never been HOSPITALIZED, had surgery, or have any medical CONDITION/S that required TREATMENT.** **(List MOST RECENT first)**

ILLNESS • INJURY • SURGERY • Date • HOSPITAL • DOCTOR • OUTCOME • list ALL spinal, procedures

_____
_____
_____
_____
_____
_____
_____

Have you ever had a blood transfusion? [ ] YES [ ] NO If so approximate dates/reaction:
Did you have any problem? [ ] YES [ ] NO

OCCUPATIONAL/WORK PLACE CONCERNS: Check if your work exposes you to the following

__ Heavy Lifting Aprox. Weight Lifted: _____lbs __ Hazardous Substance _____
__ Stress __ Other:

FAMILY HISTORY

• Check if a biological relative (Mother, Father, Sibling) had any of the following conditions
[ ] **UNKNOWN** (Adopted)

__ Back Problems	__ Arthritis	__ Asthma	__ High Blood Pressure	__ Alcoholism
__ Back Surgery	__ Gout	__ Hay Fever	__ Stroke	__ Chemical Dependency
__ Neck Problems	__ Cancer	__ Tuberculosis	__ Heart Disease	__ Other
__ Neck Surgery	__ Brain Tumor	__ Diabetes	__ Kidney Disease	

RELATION	STATE OF HEALTH D- Deceased E-Excellent G-Good F-Fair P-Poor	Current Age If Deceased, age at death and Cause of Death (if known)
Father		
Mother		
[ ] Brother [ ] Sister		
[ ] Brother [ ] Sister		
[ ] Brother [ ] Sister		
[ ] Brother [ ] Sister		
[ ] Brother [ ] Sister		

ADDITIONAL INFORMATION you consider important for the doctor to know regarding your condition:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors that I may have made in the completion of this form.

_____ _____
Signature (If other than patient, note relationship to patient) **Date**

_____ _____
Physician Reviewed By **Date**