# CARDINAL NEUROSURGERY & SPINE, INC.
## Daniel L. Kitchens, M.D., F.A.C.S.

**NAME:** ______________________________________________ **Birthdate:**__________________

**Date of Last Physical Exam:** ___________ **Family MD:** ___________________________
**What is the reason for your visit:** [ ] Neck [ ] Back [ ] Carpal Tunnel [ ] Ulnar Nerve

**ALLERGIES** List Below▼
______________________
______________________
______________________
______________________
______________________
[ ] 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
__

**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

**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
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**

__ AIDS __ HIV Positive
__ 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
__ Emphysema
__ Epilepsy
__ Fibromyalgia
__ Glaucoma
__ Goiter
__ Gonorrhea
__ Gout
__ Heart Disease
__ Hepatitis
__ Hernia
__ Herpes
__ High Cholesterol

__ Kidney Disease
__ Liver Disease
__ Measles
__ Migraine Headache
__ Miscarriage
__ Mononucleosis
__ Multiple Sclerosis
__ Mumps
__ Osteoporosis
__ Fosamax __ Boniva
__ Actonel
__ ___________________
__ Pacemaker __AICD
__ Pneumonia
__ Polio
__ ___________________
__ ___________________

__ Prostate Problems
__ Psychiatric Care
__ Rheumatic Fever
__ Scarlet Fever
__ Seizures
__ Sleep Apnea
__ Stroke
__ Suicide Attempt
__ Thyroid Problems
__ Tonsillitis
__ Tuberculosis
__ Typhoid Fever
__ Ulcers
__ Vaginal Infections
__ Venereal Disease
__ ___________________
__ ___________________



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

## 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** **E**-Excellent **F**-Fair **D**- Deceased **G**-Good **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**