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

NAME: ____ **Date:** ______________

Date of Birth: ______________ **Family MD:** ________________________________

What is the reason for your visit: [ ] Neck [ ] Back [ ] Carpal Tunnel [ ] Ulnar Nerve
Referred by: [ ] Self [ ] Friend/Family Member [ ] Insurance [ ] Provider:

PHARMACY: ____________________________ **Phone No:** ____________________________

MEDICATIONS Please write ALL the medications you take OR attach list (name and dose)

____

____

____

____

____

____

ALLERGIES Please write your allergies to medications or food

____

____

____

Are you allergic to LATEX? YES / NO I don't have allergies to medications __________

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

__ Arthritis
__ Cancer

__ Asthma
__ Emphysema
__ Sleep Apnea
___ CPAP __ Oxygen

__ Liver Disease
__ Hepatitis

__ Kidney Disease

__ Osteoporosis
__ Fosamax __ Boniva
__ Actonel

__ Seizures

__ Heart Disease
__ Chest Pain
__ Irregular Heart Beat
__ Rapid Heart Beat
__ High Cholesterol
__ Anemia
__ Stroke
__ TIA
__ Myocardial Infarction
__ High Blood Pressure
__ Low Blood Pressure
__ Poor Circulation
__ Valve problem/replacement
__ Varicose Veins
__ Swelling of Ankles
__ Stent
__ Pacemaker
__ AICD

__ Bleeding Disorders
__ History of blood clots
__ Blood Thinners
__ ASA __ 81 __325
__ Plavix __Coumadin

DIABETES
__ Last A1C level ______
Insulin Yes No

INFECTION HISTORY
__ MRSA
__ VRE
__ C-DIFF
__ HIV POSITIVE

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

____

HOSPITALIZATIONS

- Please list any surgeries you have had in the past with approximate year, surgeon, and hospital

____

____

____

____

____

____

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

TREATMENTS

PHYSICAL THERAPY: (# OF VISITS / PROVIDER / DATES)

____

Traction ___ Aqua Therapy___ TENS unit ___ Back Brace ___

CHIROPRACTOR: (# OF VISITS / PROVIDER / DATES)

____

PAIN MANAGEMENT TREATMENT: (# OF VISITS / PROVIDER / DATES)

____

Epidural Steroid Injections _____
How many in last year? _____

Spinal Cord Stimulator ____

DIAGNOSTIC STUDIES

(Check all that apply)

___ X-rays
___ MRI scan
___ Myelogram/CT
___ CT scan

___ Discogram/CT
___ Bone Scan
___ Arteriogram / Venogram
___ Doppler / Vascular Studies

EMG/NCV studies
__ right arm __ left arm
__ right leg __ left leg
__ EEG __ Sleep Studies

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**