MISSOURI SPINE INSTITUTE

John D. Spears, D.O.

Date: _________/_________/__________

Patient Name: ____

Date of Birth: ______/______/______ Age: ______ Sex: M F

Address:____

____

Best number to contact you: (_______)-_________-________

Alternate contact number: (________)-________-__________

Office Use Only

Right/Left Handed

BP: ___________/__________ Pulse: _________

Height: __________ Weight: __________ BMI: ___________

Please tell us how you were referred to our office:

- ☐ Family doctor/another physician: _________________
- ☐ Family friend/relative: ___________________________
- ☐ Previous patient of Dr. Spears: ____________________
- ☐ Radio Advertisement
- ☐ T.V. Advertisement
- ☐ Magazine Advertisement
- ☐ Web-site (*www.mospineinstitute.com*)
- ☐ Other:

Reason for today's visit/chief complaint:

____

____

____

____

When did the problem begin/Date of injury? __________________ How did the injury occur? ______________________________

****_**Did this injury happen at work**_? **YES** NO If yes, how? ____

(If yes, and you have an existing claim *or* you have not yet filed a claim to your employer, please let the receptionist know *prior* to your appointment)

Is this injury/problem a result of a motor vehicle accident? YES NO If yes, explain?_________________________________

What area of the body do you have pain/problem(s)? ____

Do you have radiating pain, numbness or weakness? YES NO If yes, where? ______________________________________

Is the problem getting worse, better or staying the same? ____

What activities can you *NOT* do because of this? ____

Have you had this problem before? YES NO Have you seen another doctor for this problem? YES NO

If yes, name of doctor & treatment provided: ____

Have you had a nerve conduction study or an EMG performed ***recently***? YES NO If yes, when and by whom? ___________

Have you ever had any Epidural Steroid Injections done ***recently***? YES NO If yes, when? ______________ How Many? ______

If you *have* had ESI's, did they provide you any relief, even if it was temporary? YES NO If yes, how long?______________

Have you had Physical Therapy ***recently***? YES NO If yes, when? ______________Did PT help your symptoms? YES NO

Have you had any other treatment(s) not mentioned above for this problem? YES NO If yes, please explain: ___________

Current Medications*:* ☐ ***See attached list***

_______________	__________________	_________________	_________________	_________________
_______________	__________________	_________________	_________________	_________________
_______________	__________________	_________________	_________________	_________________

Do you have any *medication allergies*? ☐ NO If *yes*, please list: ________________________________

Missouri Spine Institute- Past Medical History:

Do ***you*** have or had any of the following medical conditions/diseases:

☐ Liver ☐ Heart ☐ Lung ☐ Diabetes ☐ Blood Clots
☐ Kidney ☐ Cancer ☐ Blood Pressure ☐ Arthritis ☐ Seizure

☐ Other, Explain: ____

When was your last tetanus shot? ____________________

Have *you* ever had any surgeries? If **yes**, please list below:

____________________________ ____________________________ ________________________
____________________________ ____________________________ ________________________
____________________________ ____________________________ ________________________
____________________________ ____________________________ ________________________

Have *you* ever been hospitalized for any reason ***other than*** the surgeries listed above? If **yes**, please list below:

____________________________ ____________________________ ________________________
____________________________ ____________________________ ________________________

(Females only):
Menstrual History: Age of onset: _______ Regular periods: ______ Age of menopause: ______

Are you pregnant or currently trying to get pregnant? YES NO

Family History:

Do any of your immediate ***relatives*** have any of the following medical conditions/diseases?

☐ High Blood Pressure ☐ Low Blood Pressure ☐ Strokes ☐ Heart Disease
☐ Arthritis/Gout ☐ Parkinson's disease ☐ Epilepsy ☐ Tuberculosis
☐ Alcoholism ☐ Lung Disease ☐ Diabetes ☐ Kidney Disease
☐ Nervous Breakdown ☐ Bleeding Tendency ☐ Heart Attack ☐ Cancer (Type): _________________

If alive:					**If deceased:**
Father:	Age_____	Health (circle one) Good	Fair	Poor	Age: _____ Cause: _________________
Mother:	Age_____	Health (circle one) Good	Fair	Poor	Age: _____ Cause: _________________
Siblings:	Age_____	Health (circle one) Good	Fair	Poor	Age: _____ Cause: _________________
(brothers & sisters)	Age_____	Health (circle one) Good	Fair	Poor	Age: _____ Cause: _________________

Social History:

Highest Level of Education: ________________________

Employed: ☐ No ☐ Yes If yes, where? ____

Have you ever lived outside the United States? ☐ No ☐ Yes If yes, where? _____________________________

Military Service: ☐ No Yes ☐ If yes, rank and type of discharge: ____________________________________

Are you a smoker? ☐ No ☐ Yes If yes, how much? ____________How much alcohol do you consume? _________

Missouri Spine Institute- Review of Systems:

Please *circle* if you have any of the following:

Eyes**:**

Redness/Discharge	Yes	No
Glasses or Contacts	Yes	No
Blurred/Double Vision	Yes	No
Cataracts	Yes	No
Glaucoma	Yes	No
Other: ________________________		

Ears/Nose/Throat:

Sore throat	Yes	No
Nosebleed	Yes	No
Runny Nose	Yes	No
Hoarse	Yes	No
Hearing Loss	Yes	No
Other: ________________________		

Cardiovascular:

Chest Pain	Yes	No
Heart Murmur	Yes	No
Lower Leg Swelling	Yes	No
Irregular Heart Rate	Yes	No
High Blood Pressure	Yes	No
Other: ________________________		

Respiratory:

Shortness of Breath	Yes	No
Cough	Yes	No
Asthma	Yes	No
Coughing up blood	Yes	No
Hay fever with wheezing	Yes	No
Post Nasal Drip	Yes	No
Other: ________________________		

Gastrointestinal:

Diarrhea	Yes	No
Abdominal pain/bloating	Yes	No
Gallstones	Yes	No
Ulcers	Yes	No
Jaundice	Yes	No
Bloody stools	Yes	No
Other: ________________________		

Genitourinary:

Burning/Painful Urination	Yes	No
Vaginal/Penile Discharge	Yes	No
Urinary Frequency	Yes	No
Unable to control urine	Yes	No
Blood in urine	Yes	No
Other: ________________________		

Musculoskeletal:

Pain muscle	Yes	No
Neck/Back pain	Yes	No
Joint pain or swelling	Yes	No
Arm/leg inflammation	Yes	No
Difficulty moving limbs	Yes	No
Other: _________________________		

Skin/Breast:

Rash	Yes	No
Lesions	Yes	No
Skin Cancers	Yes	No
Eczema	Yes	No
Masses	Yes	No
Other: _________________________		

Neurological:

Headache	Yes	No
Numbness/Weakness	Yes	No
Seizures	Yes	No
Paralysis	Yes	No
Other: _________________________		

Psychiatric:

Change in mental state	Yes	No
Confusion	Yes	No
Depression	Yes	No
Agitation	Yes	No
Other: __________________________		

Endocrine:

Fatigue	Yes	No
Increase in hair growth/loss	Yes	No
Heat Intolerance	Yes	No
Increased thirst	Yes	No
Other: ___________________________		

Hematologic/Lymphatic:

Bleeding Tendency	Yes	No
Lymph Node enlargement/pain	Yes	No
Anemia	Yes	No
Other: ___________________________		

Allergy/Immunology:

Runny Nose	Yes	No
Skin- Itching/Rash	Yes	No
Asthma	Yes	No
Sneezing	Yes	No
Other: ____________________________		

Physician's Signature:____ **Date**: _______/________/______