GEORGIA SPINE
& Orthopedics

Established Patient History Update

Patient Name : ________________________ Date of Birth : _________ Today's Date: _________
What is the reason for today's visit? ____
*Please fill out any changes that have occurred **since your last visit** with Georgia Spine and Orthopedics.

Medications

□ No Changes

*Please list any changes to your medication list:

Allergies

□ No Changes

*Please list any changes to your allergies:

Medical History

□ No Changes

*Please list any current non-spinal medical problems, even if under control (i.e. high blood pressure, cancer, diabetes, etc.):

Surgical History

□ No Changes

*Please list any recent surgeries you have had:

Social History

□ No Changes

Are you currently employed? □ Yes □ No

What is your current work status?

□Out of Work □Light Duty □Full Duty □Retired

Smoking Status □Never □Former □Current

How much do you smoke? ____________

Alcohol Intake:

□None □Occasional □Moderate □Heavy

Illicit Drugs: ____________ □None

Review of Systems (Check boxes that apply)

□ Recent unexplained weight loss
□ Recent unexplained weight gain

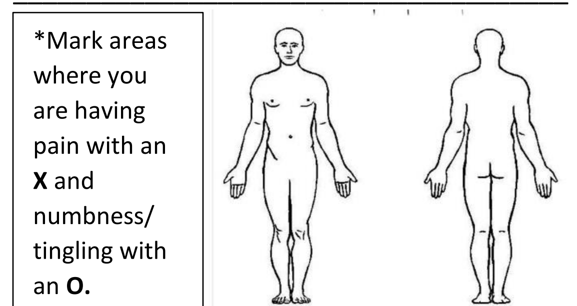
□Fatigue	□Numbness/Tingling
□Weakness	□Headaches
□Seizures	□Memory Loss
□Tremors	□Dizziness
□Irregular Heartbeat	□Chest Pain
□Abdominal Pain	□Diarrhea
□Difficulty Urinating	□Shortness Breath
□Night Sweats	□Itching/Hives

Symptoms

Describe any new symptoms:

____

*Mark areas where you are having pain with an **X** and numbness/ tingling with an **O.**



Please rate your pain NOW:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Ever

Please rate your pain AT ITS WORSE:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Ever

Have you had any tests or treatments since your last visit with us? □Yes □No

If yes, what did you have done?

____

Did this treatment help? □Yes □No