Bethesda Spine & Posture

Bethesda Spine & Posture
4733 Elm St. Ste 300, Bethesda, MD 20814
Tel: 301.656.2435 • Fax: 301.986.6960
www.bethesdaspineandposture.com

Please take a few minutes to complete this worksheet.
This information will help us to provide better care.

Name: _____
Height: _____ **Weight:** _____

Medical History:
Have you ever had or been told you have (Check all that apply)?

Cardiovascular:
☐ Chest Pain or Angina
☐ Heart Disease
☐MI, Heart Attack, Blocked artery
☐ Congestive heart failure
☐High Blood Pressure
☐ Peripheral vascular disease
☐Abnormal heartbeat
☐Pacemaker
☐Angioplasty or heart Cath
☐Rheumatic fever
☐Damaged heart valve

Respiratory:
☐ Asthma
☐Shortness of Breath
☐Emphysema
☐ TB

Metabolic:
☐ Diabetes
☐Thyroid disease
☐ Adrenal gland problem
☐ Steroid use

Neurological:
☐ Multiple sclerosis
☐Seizures/Fainting spells/dizziness
☐Stroke
☐Headaches / Migraines
☐ALS

Liver/Kidney/Blood:
☐ Kidney disease
☐ Anemia
☐ Dialysis
☐ Liver disease

Gastrointestinal:
☐Ulcers, heartburn, reflux
☐Diverticulitis or Colitis

☐Gallbladder
☐Hepatitis (Type ____)
☐Dysphagia

What medications have you tried (Circle)

NSAIDS: Aspirin, Ibuprofen, Advil, Motrin **Relaxants:** Flexeril, Valium, Xanax, Ativan **Sleep Medicines:** Ambien, Benadryl **Antidepressants:** Cymbalta, Amitriptyline **Narcotics:** Tramadol**,** Vicodin, Codeine, Percocet, MS Contin, Demerol, Morphine, Dilaudid, Methadone.

Neuropathic Medication: Gabapentin, Lyrica

Other_____

Other:
☐ Easy Bruising or bleeding
☐ Anticoagulants (Blood Thinners)
☐ Depression or Anxiety
☐Arthritis, Rheumatism
☐ Cancer_____
☐Other: _____

☐ Fibromyalgia
☐ Lupus
☐ HIV/AIDS
☐ Osteopenia/osteoporosis
☐ Chronic pain
☐ Falls

What treatments have you tried?
☐Exercise
☐ Chiropractic
☐ Brace
☐ Heat
☐ Nerve Block
☐ TENS Unit
☐ Psychologist
☐ Surgery
☐ Massage
☐Acupuncture
☐ Physical Therapy
☐ Ice
☐Biofeedback Therapy
☐Traction

Do you currently use a:

☐ Cane ☐ Walker ☐ Wheelchair ☐ Hearing aid
☐ Glasses

Social History

☐ Alcohol _____ Drinks per day
☐ Smoking_____ Packs per day
☐ Other drug use (e.g. Cannabis, IV drugs…) _____

Family History:
☐Maternal_____
☐Paternal_____

ROS: Please circle if you are currently having any of the following:

☐Fever, Chills, night sweats, Weight loss, malaise,
☐Cough, shortness of breath, wheeze
☐ Weakness or paralysis of arms and legs
☐Headaches How often? _____
☐Dizziness, vision change, lightheadedness
☐Swelling or Rash _____
☐Abdominal Pain, Nausea/vomiting
☐Change in bowel habits, bowel/bladder control loss
☐Chest Pain, Palpitations
☐Pregnant or possibly pregnant?
☐Other: _____

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Where is most of your pain? _____
_____
Does it go anywhere else? Yes or No
If yes so where? _____
When did your pain start? _____
How long have you had this pain? _____
Did it start _____ ☐ Gradually ☐ Suddenly ☐ Not sure

How often do you experience this pain?
_____ Constant _____ Comes and Goes

Is your pain getting _____ Better _____ Worse
_____ Staying the same

Have you had any X-Rays or MRIs done? Yes or No
If yes so, when, and where? _____
_____