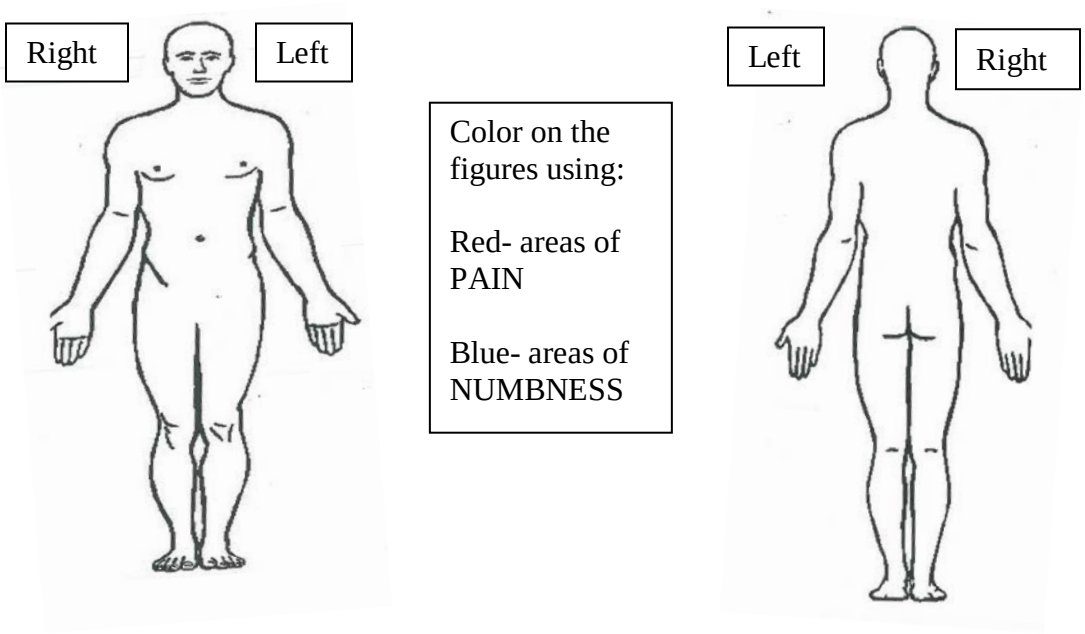
HEALTH HISTORY

When did the pain start? _____

Are symptoms worsening? Y N

If worsening, when did it start getting worse? _____

Location of Worst Pain:



Pain Quality: Burning, Continuous, Intermittent, Radiating, Sharp, Stabbing, Throbbing, Numbness, Pain, Tingling _____

Pain Better with: Activity, Cold, Elevation, Heat, In the evening, In the morning, Massage, Movement, Over the Counter medications, Prescription pain medications, _____

Pain Worse with: Activity, Cold, Elevation, Heat, In the evening, In the morning, Massage, Movement, Rest, After Surgery, _____

Is this a work related or accident related injury? Y N

If your symptoms are related to an accident or injury give date and describe event: _____

_____

Are you currently working? Y N

Occupation_____

Do you plan to return to work? Y N

Current restrictions: _____

Who else have you seen for this pain? _____

Have you had any of the following done for the same pain that Dr. Jones or Dr. Landers is seeing you for?

Treatment	Yes/ No	Did you get relief? Yes/No	Date
Pain Injections/ Procedures			
Physical Therapy			
Spine Manipulation			
TENS Unit			
Other			

Have you had any radiological studies done within the past 5 years?

TEST	Yes/ No	Date/ Place
MRI		
CT Scan		
Discogram		
Myelogram		
EMG/ NCT		
Plain X-Ray		
Bone Scan		
Other		

ALL PREVIOUS SURGERIES	APPROXIMATE DATES
Back Surgery	
Neck Surgery	
Appendix	
Bladder Surgery	
Cardiac Stents	
Colon Resection	
C-Section	
Gallbladder	
Gastric Bypass	
Heart Bypass Surgery	
Hernia Repair	
Hip Surgery	
Hysterectomy	
Knee Surgery	
Mastectomy	
Pacemaker	
Surgery for Cancer	
Tonsillectomy	
Tubal Ligation	
Wisdom Teeth	
Other	
Other	
Other	
Other	

Problems with: (Please circle all that apply)

Head: Concussion, Skull fracture, Trauma, Stroke, TIA

Headaches: Migraine, Tension, Muscular

Neurologic Problems: Memory loss, Coordination problems, Confusion, Alzheimer's, Dementia, Dizziness, Muscle weakness

Seizures: Epilepsy, Grand Mal

Vision Problems: Blindness, Glasses, Contacts, Glaucoma

Difficulty Hearing: Deafness, Ménière's disease, Hearing aids

Neck: Surgery, Whiplash, Fracture, Cancer, Muscle sprain, Pain, Stiffness

Thyroid: Hypothyroidism, Hyperthyroidism, Goiter, Thyroid cancer

Autoimmune: Lupus, Graves Disease, Hashimoto's Thyroiditis, Diabetes Type 1, Multiple Sclerosis

Lung: Asthma, COPD, Emphysema, Bronchitis, Pneumonia

Heart: Fast/ Slow Heartbeat, High/ Low Blood pressure, Chest pain, Heart attack, Pacemaker, CHF

Blood Disorders: Low platelets, Anemia, Bruise easily, Leukemia, Von Willebrand disease, HIV, AIDS

Current Blood Thinners: Coumadin/ Warfarin, Plavix, Aspirin, Pradaxa, Aggrenox, _____

Liver: Hepatitis A, Hepatitis B, Hepatitis C, Alcohol induced, Drug induced

Diabetes: Type 1, Type 2, Hypoglycemia

Kidney: Dialysis Hemodialysis/ Peritoneal dialysis, Renal failure, Kidney stone, Polycystic disease, Kidney infection

Stomach/ Bowel: Gastric reflux, Nausea, Peptic ulcer disease, Gastritis, Constipation, Diarrhea, Irritable bowel

Joint Replacement: Left/Right Hip, Left/ Right Shoulder, Left/ Right Knee

Extremity (Arm/Leg): Prothesis: Left/Right Arm, Left/Right Leg, Fractures: Left/Right Arm, Left/Right Leg, Paraplegia, Quadriplegia

Arthritis: Rheumatoid, Osteoarthritis, Fibromyalgia

Cancer: Breast, Liver, Kidney, Lung, Skin, Bladder, Thyroid, Brain, Stomach, Colon

Reaction to Anesthesia: Nausea, Vomiting, Malignant hyperthermia

Tobacco Use or Exposure: Never smoked, past smoker, Smoking Cigarettes/Cigars_____#/per day, Chew, Second Hand Smoke, Live with a smoker

Psychological: Depression, Anxiety, Bipolar, Schizophrenia

Alcohol Use: Social Drinking, History of Alcohol Abuse, None

Street Drug Use (Current): Yes/No

Patient Medications

Pharmacy Name/Address/Phone#_____

Allergies/Reaction _____

Medication Name	Strength	How often are you taking the medication?

Midwest Surgery Center

In general, the HIPPA privacy rule gives individual the right to request a restriction on disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI is made by alternative means.

I wish to be contacted in the following manner (check all that applies):

____**Home Phone**: _____

___ OK to leave message with detailed information

___ Leave message with call-back number only

____ **Work Phone**: _____

___ OK to leave message with detailed information

___ Leave message with call-back number only

____**Cell Phone**: _____

___ OK to leave message with detailed information

___ Leave message with call-back number only

____ **Written Communication**

___ OK to mail to my home address

___ OK to fax to this number: _____

____ **Email**: _____

I authorize Midwest Surgery Center, Pain Management Associates, and Kansas Spine Institute to release information, including but not limited to treatment, results, scheduling, and billing, to:

Name	**Phone**	**Relationship**
_____	_____	_____
_____	_____	_____
_____	_____	_____

1. I acknowledge that I received a copy of Midwest Surgery Center Notice of Privacy Practices with the effective date of April 14, 2003.
2. I acknowledge that I received a copy of Midwest Surgery Center Policy on Referrals and Authorizations with the effective date of January 1, 2008.

Patient Signature_____ Date_____

Patient's authorization to release medical information and claim payment authorization

I authorize any physician, hospital, or any other medical provider to release to my insurance company or its representative any information regarding medical history, symptom, treatment, examination results or diagnosis. I authorize filing of insurance and payment of medical benefits to provider. I understand that I am financially responsible for any balance not covered by my insurance carrier.

Patient Signature_____ Date_____