NEUROSURGERY AND SPINE SPECIALISTS OF CHARLESTON
ROPER ST. FRANCIS PHYSICIANS

SUMMARY OF MEDICAL HISTORY DATE: _____

PATIENT NAME: _____ MRN: _____

AGE:_____ HANDEDNESS: Right ☐ Left ☐ Are you currently working? ☐ Yes ☐ No

If no, where and when did you last work?_____

CHIEF COMPLAINT: (*primary reason you are here today*)_____

_____

_____

PAST MEDICAL HISTORY

Do you now have or have you ever had any of the following illnesses? (*please check all that apply*)

- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes (high blood sugar)
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures (or broken bones)
- ☐ Hepatitis
- ☐ Hypertension (high blood pressure)
- ☐ High Cholesterol
- ☐ Kidney Failure
- ☐ Myocardial Infarction (heart attack)
- ☐ Other Heart Disease
- ☐ Stroke
- ☐ Ulcers

PAST SURGICAL HISTORY

DATE	OPERATION

WORKER'S COMPENSATION / VEHICULAR ACCIDENT INFORMATION

Is this illness/injury related to employment? Yes ☐ No ☐ a motor vehicle accident? Yes ☐ No ☐

Do you have legal counsel? Yes ☐ No ☐ If yes, name and number of attorney: _____

_____

Name of Insurance Company: _____

Contact/Adjuster: _____ Claim #_____ Phone # _____

Have you ever been diagnosed with MRSA? ☐ No ☐ Yes

MRSA (Methicillin-resistant Staphylococcus aureus) is a bacterial infection that is highly resistant to some antibiotics.

When were you diagnosed? _____ When were you last tested for MRSA? _____

ALLERGIES Please list all known allergies and reactions below:

Allergy Reaction

_____

_____

_____

_____

CURRENT MEDICATIONS

Medication Name / Strength / How medication is taken: _____

_____

_____

_____

_____

FAMILY HISTORY

FAMILY MEMBER	ALIVE	AGE	DECEASED	AGE OF DEATH	CAUSE OF DEATH	SIGNIFICANT ILLNESSES
Father						
Mother						
Brother/Sister						
Grandmother						
Grandfather						
Spouse						
Son/Daughter						

SOCIAL HISTORY

Occupation: _____

Do you smoke? ☐ No ☐ Yes

If Yes, for how long? _____

Packs per day: _____

Marital Status:

☐ Single ☐ Divorced

☐ Married ☐ Separated

☐ Widowed

Do your drink alcohol? ☐ No ☐ Yes Number of drinks per day: _____ per week: _____

Do you drink coffee or tea? ☐ No ☐ Yes Number of drinks per day: _____ per week: _____