SYNERGY
PHYSICIAN GROUP, P.A.

The Leader in Spinal Medicine and Minimally Invasive Spinal Surgery

PATIENT NAME: _____ ACCOUNT #: _____
DATE OF BIRTH: _____ SSN: _____
HEIGHT: _____ WEIGHT: _____

PAST MEDICAL HISTORY

PATIENT MEDICAL HISTORY

- ☐ HEART ATTACK
- ☐ HEART FAILURE
- ☐ CHEST PAIN
- ☐ DIABETES
- ☐ STROKE
- ☐ ANEMIA
- ☐ SEIZURES
- ☐ HIGH BLOOD PRESSURE
- ☐ FREE/ EASY BLEEDING
- ☐ ULCERS
- ☐ REFLUX
- ☐ OSTEOPOROSIS
- ☐ EMPHYSENA/ COPD
- ☐ ASTHMA
- ☐ TUBERCULOSIS
- ☐ DEPRESSION
- ☐ ANXIETY
- ☐ SLEEP APNEA
- ☐ HEPATITIS A, B OR C
- ☐ HIV/ AIDS
- ☐ CANCER—TYPE_____
- ☐ ARTHRITIS—WHERE_____
- ☐ OTHER—SPECIFY_____

FAMILY MEDICAL HISTORY

- ☐ HEART ATTACK
- ☐ HEART FAILURE
- ☐ CHEST PAIN
- ☐ DIABETES
- ☐ STROKE
- ☐ ANEMIA
- ☐ SEIZURES
- ☐ HIGH BLOOD PRESSURE
- ☐ FREE/ EASY BLEEDING
- ☐ ULCERS
- ☐ REFLUX
- ☐ OSTEOPOROSIS
- ☐ EMPHYSENA/ COPD
- ☐ ASTHMA
- ☐ TUBERCULOSIS
- ☐ DEPRESSION
- ☐ ANXIETY
- ☐ SLEEP APNEA
- ☐ HEPATITIS A, B OR C
- ☐ HIV/ AIDS
- ☐ CANCER—TYPE_____
- ☐ ARTHRITIS—WHERE_____
- ☐ OTHER—SPECIFY_____

PREVIOUS SURGERY

	DATE OF SURGERY
☐ APPENDIX	_____
☐ GALLBLADDER	_____
☐ TONSILS	_____
☐ KIDNEY	_____
☐ TUBAL LIGATION	_____
☐ KNEE	_____
☐ HYSTERECTOMY	_____
☐ HIP	_____
☐ C-SECTION	_____
☐ HEART BYPASS	_____
☐ HEART CATH	_____
☐ BACK	_____
☐ NECK	_____
☐ OTHER_____	_____

OTHER PHYSICIAN CARE

	NAME	PHONE NUMBER
PRIMARY CARE:		
CARDIOLOGIST:		
INFECTIOUS DISEASE:		
NEPHROLOGIST:		
VASCULAR SURGEON:		
ENDOCRINOLOGIST:		

ALLERGIES

_____
_____
_____

REVIEW OF SYMPTOMS: DO YOU HAVE ANY OF THE FOLLOWING?

- ☐ CHEST PAIN/ TIGHTNESS
- ☐ SWELLING IN ARMS. LEGS
- ☐ WHEEZING/COUGHING
- ☐ JOINT STIFFNESS
- ☐ WEAR DENTURES OR PARTIAL
- ☐ FEVER/ CHILLS
- ☐ NAUSEA/ VOMITING
- ☐ CONSTIPATION
- ☐ HEART MURMUR
- ☐ LEG CRAMPS
- ☐ BACK PROBLEMS
- ☐ TINGLING/ NUMBNESS
- ☐ NECK PROBLEMS
- ☐ WEIGHT GAIN/ LOSS
- ☐ INSOMNIA
- ☐ SWEATING
- ☐ IRREGULAR HEARTBURN
- ☐ SHORTNESS OF BREATH
- ☐ LOSS OF FEELING IN LEGS
- ☐ MUSCLE STIFFNESS
- ☐ HEADACHE
- ☐ WEAKNESS
- ☐ LOW BLOOD SUGAR
- ☐ SLEEP DISTURBANCES
- ☐ WEAKNESS IN ARMS/ LEGS
- ☐ SHORTNESS OF BREATH RESTING
- ☐ LOSS OF FEELING ON ONE SIDE
- ☐ WEAR GLASSES OR CONTACTS
- ☐ SLEEP INTERRUPTED BY URINATION
- ☐ EASILY FATIGUED
- ☐ ITCHING OR RASH
- ☐ HIGH STRESS LEVELS OR TENSE

MEN ONLY

- ☐ PAIN OR SWELLING IN TESTICLES
- ☐ DISCHARGE FROM PENIS
- ☐ PROBLEMS WITH ERECTION AND/ OR EJACULATION

WOMEN ONLY

MENSTRUAL PROBLEMS ☐ YES OR ☐ NO
_____ NUMBER OF PREGNANCIES
_____ NUMBER OF LIVE BIRTHS
_____ LAST MENSTRUAL CYCLE

SOCIAL HISTORY

☐ **TOBACCO USE**
☐ PAST OR ☐ PRESENT
HOW MUCH? _____
HOW LONG? _____

☐ **ALCOHOL USE**
☐ PAST OR ☐ PRESENT
HOW MUCH? _____
HOW LONG? _____