SPINE & ORTHOPAEDICS OF ATLANTA, LLC
DAMIEN A. DOUTE, MD, MPP, FAAOS

Past Medical History & Review of Systems

PATIENT NAME: _____ **DATE:** / /

AGE: _____ **Date of Birth:** _____ **MALE/FEMALE (Circle one)**

Race/Ethnicity: _____ **Height:** _____ **Weight:** _____

Occupation: _____ **Language Spoken:** _____

Significant Medical Problems(Heart, Cancer, Diabetes, Lung dis): _____

ARE YOU ALLERGIC TO ANY MEDICINES? ☐ YES ☐ NO

ARE YOU ALLERGIC TO LATEX? ☐ YES ☐ NO

ARE YOU ALLERGIC TO NICKEL, OR OTHER METALS? ☐ YES ☐ NO

Are you a smoker? ☐ YES ☐ NO **If YES, how much, often?** _____

If you quit smoking, when did you quit and how long did you smoke? _____

Are you currently taking any medications?(Including over counter)_____ **If YES, Fill out attached meds form**

Referring Physician/PCP: _____

Has your problem today been treated elsewhere? _____

If YES, when and where?

Have you had any diagnostic tests performed for this problem (xray, MRI, CT) _____

If YES, what, when and where? _____

CURRENT PROBLEM

WHY ARE YOU HERE? _____

Is this the result of an injury? Yes No **Work Related ?** Yes No

Auto Related? Yes No **If YES, date of injury** / /

Briefly describe your complaints (where it hurts and what you feel):

How Long has this been a problem? _____

If this is due to an ACCIDENT, what happened? _____

Please list any additional concerns you want to discuss, _____

And relevant family history:

YOUR PAIN ON 1(NOT BAD) TO 10 (HORRIBLE) Scale is:

I Authorize Spine and Orthopaedics of Atlanta, LLC, to release accident information to insurers if Necessary to determine benefits payable. A copy of this signature is as valid as the original.

Signature: _____ **Date:** _____

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Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____

Occupation/Job Duties (If student, name of school): _____
Referring Physician/Person:

Do you consider your general health to be: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have, or have you ever had, any of the following? (Check all that apply)

☐ Arthritis Bursitis	☐ Glaucoma	☐ Stroke
☐ Bled a lot after surgery/injury	☐ Hayfever	☐ T.I.A.
☐ Cancer	☐ Thyroid Disease	☐ Gall bladder trouble
☐ Diabetes (Sugar)	☐ Asthma	☐ Hemorrhoids
☐ Epilepsy or seizures	☐ Lung Disease	☐ Hepatitis or yellow jaundice
☐ Gout	☐ Pneumonia	☐ Hernia
☐ Leukemia	☐ Pulmonary Embolism	☐ Kidney disease
☐ Lupus	☐ Tuberculosis ("TB")	☐ Kidney stones
☐ Psoriasis	☐ Blood Clots	☐ Pancreatitis
☐ Rheumatoid Arthritis	☐ Heart attack	☐ Ulcer (Peptic or gastric)
☐ Scarlet Fever	☐ Heart disease	☐ Venereal disease
☐ Treated Psychiatric/Depression	☐ Hypertension	☐ Deformity of any body part
☐ Tumor, Growth or Cyst	☐ Rheumatic fever	☐ Loss of any part of arm or leg

Childhood Diseases: ☐ Chicken Pox ☐ Mumps ☐ Measles ☐ Rubella

In the PAST MONTHS, have you had any of the following:

YES	NO		YES	NO		YES	NO	
☐	☐	Weight Gain/Loss	☐	☐	Shortness of breath	☐	☐	Bowel/bladder problem
☐	☐	Frequent Headaches	☐	☐	Chest pain	☐	☐	Change in bowel habits
☐	☐	Head Injury	☐	☐	Had an abnormal EKG	☐	☐	Frequent diarrhea
☐	☐	Growth/Lumps on head	☐	☐	Chronic cough	☐	☐	Bloody bowel movements
☐	☐	Memory loss	☐	☐	Coughed up blood	☐	☐	Black stools
☐	☐	Ear, nose, throat trouble	☐	☐	Pain on breathing	☐	☐	Vomited up blood
☐	☐	Ringing in ears	☐	☐	Indigestion	☐	☐	Recurrent nausea/vomit
☐	☐	Decreased hearing	☐	☐	Jaundice	☐	☐	Stomach/liver trouble
☐	☐	Eye trouble	☐	☐	Numbness	☐	☐	Intestine trouble
☐	☐	Stopped up nose	☐	☐	Foot trouble	☐	☐	Fatty food intolerance
☐	☐	Nose bleeds	☐	☐	Pain on urination	☐	☐	Spicy food intolerance
☐	☐	Frequent colds	☐	☐	Sugar in urine	☐	☐	Blackouts/unconcious
☐	☐	Frequent sore throats	☐	☐	Protein in urine	☐	☐	Depression/lots of worry
☐	☐	Difficult/pain swallowing	☐	☐	Bloody/cloudy urine	☐	☐	Painful/red/swollen joints
☐	☐	Tooth/bum trouble	☐	☐	Frequent urination	☐	☐	Weak/Pain in muscles
☐	☐	Loss Bowel/bladder	☐	☐	Recurrent back pain	☐	☐	Weak/Pain in joints

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MEDICATION LIST(On Now)

MEDICATION NAME	DOSAGE/AMOUNT	GIVEN BY:

OPERATIONS/PAST SURGERIES

SURGERY	DATE	DOCTOR

PATIENT NAME DATE