CLEVELAND BACK AND PAIN MANAGEMENT CENTER, INC.

GENERAL HEALTH REVIEW

Patient Name ______________________________ Date ______________

Medical History (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, as well as psychiatric illnesses, etc.)

______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________

Surgical History

______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________

Allergies (includes medication and food allergies)

______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________

Intolerances (include side effects from previous medications, such as gastritis, nausea, constipation, etc.)

______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________

Current Medications (include vitamins and birth control pills, if applicable)

______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________

Do you have any of the following? (Circle all that apply)

Headaches	Stomach Pain	Chest Pain
Vision Problems	Nausea	Shortness fo Breath
Hearing Problems	Vomiting	Urinary Problems
Dizziness	Constipation	Rashes
Difficulty Swallowing	Diarrhea	Swollen Joints
		Chronic Fatigue

Domestic Situation

With whom do you live? ____________________

Are there an substance abuse issues in th household? Yes ________ No ________

If yes, please explain ____________________

Are you able to take care of yourself? Yes ________ No ________

If not, please enter name of caregiver ____________________

Work History

Job ____________ Years worked ________ Why did you leave?

____

____

Legal Matters

Are you presently involved in a lawsuit? Yes ________ No ________ If yes, please explain.

____

____

Substance Use

Which of the following drugs or substances, if any, have you used in the past? (Circle all that apply)
Next to each drug or substance that you've circled, indicate if you used it occasionally ("O"), frequently ("F"), or continuously ("C").

Alcohol	________	Barbiturates	________	Cocaine	________
Heroin	________	Amphetamines	________	Marijuana	________
Other	________ (specify)	Other	________ (specify)	Other	________ (specify)

Are you presently using any of the drugs or substances below? (Circle all that apply)
Next to each drug or substance that you've circled, indicate if you use it occasionally ("O"), frequently ("F"), or continuously ("C").

Alcohol	________	Barbiturates	________	Cocaine	________
Heroin	________	Amphetamines	________	Marijuana	________
Other	________ (specify)	Other	________ (specify)	Other	________ (specify)

Have you ever been treated for or have you ever had an addiction to Alcohol, Drugs or Medications?
Yes ________ No ________

Do you presently smoke cigarettes or use tobacco in any form? Yes ________ No ________

How many packs do (did) you smoke a day?

If not, did you ever smoke cigarettes or use tobacco in any form Yes ________ No ________

How many packs do (did) you smoke a day? ________ For how many years? ________