COMPREHENSIVE SPINE CARE, P.A.

NAME_____ DATE_____

PLEASE CHECK ALL **POSITIVE** CONDITIONS

- **General:** ____Fever ____Chills ____Unexplained weight loss ____Cancer
- **Eyes:** ____Glaucoma ____Blurred Vision ____Other_____
- **Cardiac:** ____Shortness of Breath ____Chest Pain ____Irregular heart beat
  ____Palpitations ____High Blood Pressure ____Other_____
- **Vascular:** ____Swelling of feet and ankles ____Other_____
- **Neurologic:** ____Frequent Headaches ____Seizures ____Double Vision
  ____Ringing in ears ____Dizziness ____Other_____
- **Urinary:** ____Frequent urination ____Hesitancy ____Blood in urine
  ____Painful urination ____Kidney Disease
- **Gastrointestinal:** ____Nausea ____Vomiting ____Blood in Stool ____Heartburn
  ____Ulcers ____Other_____
- **Respiratory:** ____Shortness of Breath ____Wheezing ____Coughing
  ____Asthma ____Other_____
- **Musculoskeletal:** ____Arthritis ____Joint Swelling ____ Other
  ____Back Pain ____Neck Pain
- **Endocrine:** ____Thyroid Abnormalities ____Cold or Heat Intolerance
  ____Diabetes ____Other_____
- **Skin:** ____Rashes ____Other_____
- **Blood:** ____Anemia ____Easy bruising or bleeding ____Past blood transfusion
  ____Other_____

ALL SYSTEMS ARE NEGATIVE: YES NO

PATIENT SIGNATURE:_____