NEW JERSEY SPINE AND ORTHOPEDIC

SCOTT S. KATZMAN, M.D.
Tel: 855-586-2615 Fax: 973-564-6092

MEDICAL HISTORY

TODAY'S DATE:

ARE YOU A JEHOVAH WITNESS? ☐ YES ☐ NO AGE: ________ SEX: ________ HT: ________ WT: ________

HEALTH HISTORY OF PATIENT

	YES	NO
ASTHMA	☐	☐
HEART TROUBLE	☐	☐
HIGH BLOOD PRESSURE	☐	☐
DIABETES	☐	☐
ARTHRITIS	☐	☐
GOUT	☐	☐
SEIZURES	☐	☐
MENTAL ILLNESS	☐	☐
KIDNEY TROUBLE / STONES	☐	☐
CANCER	☐	☐
BLEEDING DISORDER	☐	
ALCOHOLISM	☐	☐
SERIOUS INJURY	☐	☐
LUNG DISEASE	☐	☐
TUBERCULOSIS	☐	☐
PHLEBITIS	☐	☐
ANEMIA	☐	☐
STOMACH ULCERS	☐	☐
LIVER TROUBLE	☐	☐
AIDS / HIV	☐	☐
POLIO	☐	☐
STROKE	☐	☐
THYROID PROBLEMS	☐	☐
OTHER	☐	☐
REACTION TO ANESTHESIA	☐	☐

IF YES, WHAT: ______________________

LIST ALL SURGERIES WITH DATES:

____

____

____

____

____

____

____

____

____

____

____

FAMILY HISTORY

	YES	NO
STROKE	☐	☐
HEART TROUBLE	☐	☐
HIGH BLOOD PRESSURE	☐	☐
DIABETES	☐	☐
ARTHRITIS	☐	☐
GOUT	☐	☐
SEIZURES	☐	☐
MENTAL ILLNESS	☐	☐
KIDNEY TROUBLE / STONES	☐	☐
CANCER	☐	☐
BLEEDING DISORDER	☐	☐
ALCOHOLISM	☐	☐
OTHER	☐	☐

EXPLAIN ALL "YES" ANSWERS:

____

____

____

____

____

SOCIAL HISTORY

OCCUPATION: ______________________

____

____

MARITAL STATUS: ______________________

OF CHILDREN LIVING WITH YOU: ______________________

____

PRESENTLY LIVING ALONE? ☐ YES ☐ NO

SMOKER? ☐ YES ☐ NO PACKS PER DAY: ________

ALCOHOL? ☐ YES ☐ NO ☐ NEVER

OCCASIONAL? ☐ YES ☐ NO

MODERATE TO HEAVY? ☐ YES ☐ NO

DRUGS? ☐ YES ☐ NO

OVERUSE? ☐ YES ☐ NO PREVIOUS? ☐ YES ☐ NO

PAST PROBLEM? ☐ YES ☐ NO

REVIEW OF SYSTEMS

HAVE YOU HAD RECENTLY OR DO YOU NOW HAVE

	YES	NO
READING GLASSES	☐	☐
LOSS OF HEARING	☐	☐
EAR PAIN	☐	☐
HOARSENESS	☐	☐
CHILL OR FEVER	☐	☐
ABNORMAL HEARTBEAT	☐	☐
BADLY SWOLLEN ANKLES	☐	☐
CALF CRAMP WITH WALKING	☐	☐
POOR APPETITE	☐	☐
TOOTHACHE	☐	☐
STOMACH PAIN	☐	☐
ULCERS	☐	☐
FREQUENT BELCHING	☐	☐
HEMORRHIODS	☐	☐
FREQUENT CONSTIPATION	☐	☐
BLACKOUTS	☐	☐
SEIZURES	☐	☐
FREQUENT RASH	☐	☐
HOT / COLD SPELLS	☐	☐
RECENT WEIGHT CHANGE	☐	☐
NERVOUS EXHAUSTION	☐	☐

WOMEN ONLY

	YES	NO
IRREGULAR PERIODS	☐	☐
ARE YOU PREGNANT	☐	☐
VAGINAL DISCHARGE	☐	☐
ARE YOU NURSING	☐	☐
FREQUENT SPOTTING	☐	☐

OF PREGNANCIES: ______________________

REVIEWED BY:	DATE: