INTERVENTIONAL SPINE CARE & ORTHOPEDIC REGENERATIVE EXPERTS

Patient Name: _____ Room #_____

Please check off any of the following symptoms you have been recently experiencing:

☐ *No changes since last visit*

General:	☐ Chills	☐ Fever	☐ Weight Gain	☐ Weight Loss
Skin:	☐ Rash	☐ Sores	☐ Hair Loss	☐ Itching
HEENT:	☐ Vision Problems	☐ Ringing in Ears	☐ Hearing Loss	☐ Discharge
Respiratory:	☐ Cough	☐ Wheezing	☐ Shortness of Breath	☐ Sputum
Cardiovascular:	☐ Chest Pain	☐ Irregular Heartbeats	☐ Palpatations	☐ Arrhythmia
Gastrointestinal:	☐ Heartburn	☐ Constipation	☐ Nausea	☐ Vomiting
Muskuloskeletal:	☐ Neck Pain	☐ Headaches	☐ Joint Pain	☐ Muscle Pain
	☐ Upper Back Pain	☐ Swollen Glands	☐ Joint Stiffness	☐ Muscle Spasms
	☐ Lower Back Pain	☐ Deformities	☐ Joint Swelling	☐ Fatigue
Neurological:	☐ Headaches	☐ Fainting	☐ Unsteadiness	☐ Numb/Tingling
	☐ Head Injury	☐ Poor Coordination	☐ Stroke	☐ Weakness
		☐ Trouble Walking		☐ Incontinence
Psychiatric:	☐ Nervous	☐ Depression	☐ Flashbacks	☐ PTSD
Endocrine:	☐ Problems with Glands	☐ Heat Intolerance	☐ Excessive Sweating	☐ Diabetes
Hematology:	☐ Problems Clotting	☐ Abnormal Bleeding	☐ Easy Bruising	☐ Blood Thinners
Genito-Urinary:	☐ Problems	☐ Discharge	☐ Urinary Incontinence	☐ UTI

☐ **None of the Above Apply**

STOP – DO NOT WRITE BELOW THIS LINE – OFFICE USE ONLY

Last Office Visit:_____ Surgery Date: _____