Dr. Michael Rohan Spine
Board-Certified Orthopedic Surgeon • Fellowship-Trained Spine Surgeon
Specializing in Minimally Invasive Spine Surgery & Artificial Disc Replacement

NORTHEAST FLORIDA / CLAY COUNTY
1650 Corsair Lane, Suite 401, Middleburg, FL 32068
Appointments & 2nd opinions: 904-204-5000
ONLINE SPINE ENCYCLOPEDIA ABOUT BACK AND NECK PAIN AT:
MichaelRohanSpine.com

YOUR MEDICAL HISTORY page 1

1 Patient information

Chart # _____

Today's Date _____

Referring Doctor _____

Last Name _____ First Name _____ MI ___

Date of Birth (M/D/Y) _____ Age _____

Sex (M/F) _____ Height _____ Weight _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

2 Your symptoms

Are your symptoms mostly in back, neck or elsewhere? _____

_____

Date of Injury / when symptoms started: _____

_____

How long have you had these symptoms?

☐ ≤ 6 weeks ☐ ≥ 7 - 12 weeks ☐ 4 months or more

Do you have pain radiating past your knee or elbow? ☐ Yes ☐ No

Does your leg or arm ever go numb? ☐ Yes ☐ No

Have you lost bowel or bladder control? ☐ Yes ☐ No

The pain is: ☐ Constant ☐ It comes & goes

Does your pain wake you up at night? ☐ Yes ☐ No

What things makes the pain better? (rest, ice, heat, pills) _____

_____

What makes the pain worse? (sitting, standing, lifting) _____

_____

Do you have pain that radiates into the arm or leg? ☐ Yes ☐ No

(If yes, describe) _____

Lost any control over bowel or bladder functions? ☐ Yes ☐ No

(If yes, describe) _____

Any weakness or numbness in an arm or leg? ☐ Yes ☐ No

(If yes, describe) _____

How long can you: _____ Sit _____ Stand _____ Walk

Is your pain the result of a: ☐ Fall ☐ Auto accident ☐ Other (list) _____

_____

3 Current status

Is there a law suit pending on problem? ☐ Yes ☐ No

Which of the following describes you currently?

☐ Working; if yes: ☐ Full duties ☐ Limited

☐ Not working because of back or neck problem

☐ Not working because of another health problem

☐ Homemaker, retired or unemployed

How long have you been at that job? _____

Does your job require lifting, standing, sitting? ☐ Yes ☐ No

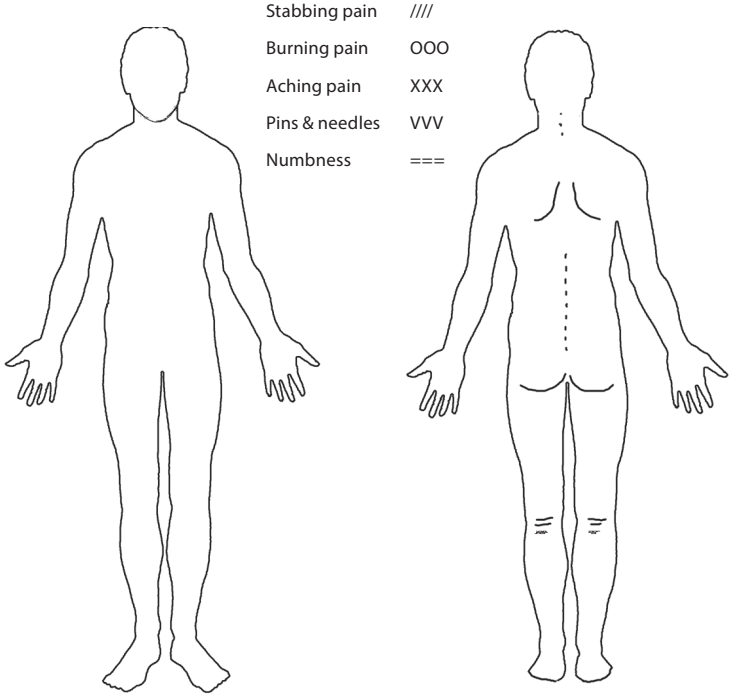
Employer at time of injury _____

4 Your pain

Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.

FRONT BACK

Stabbing pain	////
Burning pain	OOO
Aching pain	XXX
Pins & needles	VVV
Numbness	===



Circle your pain level on a scale of 1 to 10, with 10 being unbearable pain.

1 2 3 4 5 6 7 8 9 10

no pain extreme pain

Reviewed _____ Date _____

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YOUR MEDICAL HISTORY page 2

5 Previous treatments & tests

Name of the doctor that treated you FIRST for this problem and the city. _____

Have you seen a spine surgeon in the past? ☐ Yes ☐ No If YES, please provide the name of the surgeon. _____

What treatments did you have? _____

What tests have you had? ☐ CT scan ☐ MRI ☐ X-ray ☐ EMG ☐ Other (list) _____

Did you have any injections for your problem? ☐ Yes ☐ No
(If yes, describe) _____

Did these injections help? ☐ Yes ☐ No
(If yes, describe) _____

Did you have previous back or neck surgery? ☐ Yes ☐ No
(If yes, describe) _____

List any other PREVIOUS SURGERIES you had, and dates: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No
(If yes, describe) _____

Did you have physical therapy before for your problem? ☐ Yes ☐ No
(If yes, describe) _____

Did this therapy help? ☐ Yes ☐ No
(If yes, describe) _____

Do you do any special exercises for your back or neck? ☐ Yes ☐ No
(If yes, describe) _____

List any medications you are taking: _____

What other medications have you tried? _____

What do you hope we can accomplish today? _____

What other concerns do you have? _____

6 Your health

List any ALLERGIES you have to medications, foods, etc. _____

Do you have any adverse reactions to anesthesia? ☐ Yes ☐ No
(If yes, describe) _____

Do you smoke? ☐ Yes ☐ No (If yes, how many packs a day?) _____

Do you drink alcohol? ☐ Yes ☐ No (If yes, how many days a week?) _____

Do you have any of the following medical problems:

AIDS/HIV	☐ Yes ☐ No	Nerve problems	☐ Yes ☐ No
Arthritis or joint pain	☐ Yes ☐ No	Psychiatric problems	☐ Yes ☐ No
Bleeding disorders	☐ Yes ☐ No	Stomach problems	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Thyroid problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Anxiety/Depression	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Recently, have you had...	
Heart problems	☐ Yes ☐ No	Fever or chills	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	Weight loss	☐ Yes ☐ No
High blood pressure	☐ Yes ☐ No	Chest pain	☐ Yes ☐ No
Migraines/headaches	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No
Muscle diseases	☐ Yes ☐ No	Worse pain at night	☐ Yes ☐ No
Swollen ankles	☐ Yes ☐ No	Night sweats	☐ Yes ☐ No

Other problems: _____

7 Your family history

Do any family members have a history of:

Back/neck problems	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
AIDS/HIV	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No
Arthritis or joint pain	☐ Yes ☐ No	Migraines/headaches	☐ Yes ☐ No
Bleeding disorders	☐ Yes ☐ No	Muscle diseases	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Nerve problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric problems	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Stomach problems	☐ Yes ☐ No
Heart problems	☐ Yes ☐ No	Thyroid problems	☐ Yes ☐ No

Other problems? _____

Reviewed _____ Date _____

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PERSONAL INFORMATION

1 Patient information

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zip _____

Personal Phone # _____ Work Phone # _____

Social Security # _____ Medicare # _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth (M/D/Y) _____ Age _____ Sex (M/F) _____

Occupation (If retired, list prior occupation) _____

_____

Employer's Address _____

City _____ State _____ Zip _____

Emergency Contact _____ Telephone # _____

Name of Personal Doctor _____

City _____ State _____

Name of Pharmacy _____

Pharmacy Address _____

Pharmacy Phone _____

2 Person responsible for payment

(Leave blank if same as patient)

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zip _____

Personal Phone # _____ Work Phone # _____

Social Security # _____

Date of Birth (M/D/Y) _____ Age _____ Sex (M/F) _____

Occupation (If retired, list prior occupation) _____

_____

Employer's Address _____

City _____ State _____ Zip _____

3 How did you hear of us?

☐ Friend/Relative ☐ Newspaper/Magazine ☐ Yellow pages ☐ Internet ☐ Insurance directory ☐ Referral - Dr. name _____

4 Insurance information

Primary Insurance _____

Policy # _____ Group # _____

Claims Address _____

City _____ State _____ Zip _____

Insurance Telephone # _____

Name of Policy Holder _____

DOB: _____

Secondary Insurance _____

Policy # _____ Group # _____

Claims Address _____

City _____ State _____ Zip _____

Insurance Telephone # _____

Name of Policy Holder _____

DOB: _____

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CONSENT FORM

1 Financial agreement

I hereby give authorization for payment of insurance benefits to be made directly to the provider and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Insurance authorization must be obtained before a patient is seen. If I do not inform the physicians seen in this clinic of my current insurance and the insurance is denied because of no authorization, I will be responsible for payment. If authorization is not obtained from the insurance company before my scheduled appointment and I still choose to see the doctor, I will be responsible for the bill at the time of service.

Patient Name _____

Signature of responsible party _____

Today's Date _____

2 Consent for minor

I grant the physicians associated with the practice the authority to administer treatments and perform such procedures as may be deemed necessary for the patient.

Signature _____ Date _____

Relationship to patient _____

3 Notice of privacy practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area. I will be offered a copy of any amended Notice or Privacy Practices.

Signature _____ Date _____

If not signed by the patient, please indicate the relationship between the signee and the patient:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

For office use only

Date received _____ Copayment _____

Authorization required ☐ Yes ☐ No Processed by _____

Practice follow-up ☐ Yes ☐ No Date of follow-up _____

Complete the following only if the patient refuses to sign the acknowledgement

Efforts to obtain _____

Reason for refusal _____