The Back and Neck Clinics

BELLAIRE • PEARLAND

Abraham G. Thomas, M.D.

HISTORY AND PHYSICAL

Patient's Name: _____ **Date:** _____

Age: _____ **Referring Physician:** _____

Tests Performed for Pain Problems

- ☐ X – RAYS
- ☐ CAT Scan
- ☐ MRI
- ☐ Bone Scan
- ☐ Discogram
- ☐ Myelogram
- ☐ Other _____

Medications

_____

_____

Drug Allergies _____

_____

Past Medical History

_____

_____

_____

Hospitalizations (Date/Year of Problem Treated)

_____

_____

Review of Symptoms

_____

_____

Family Medical/Social History

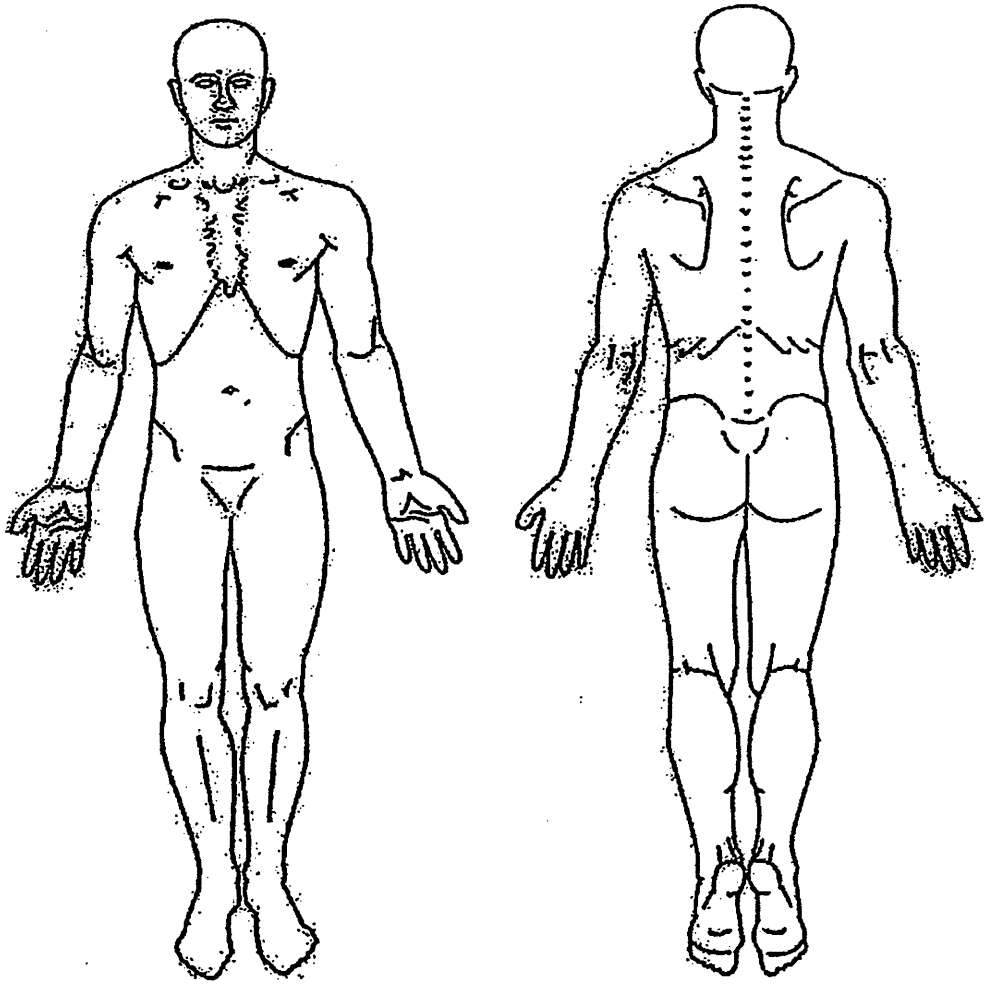
Family Disease History: _____
Do you use Illegal Drugs Past or Present: _____
Tobacco: _____**Yes** _____**No / If yes, how much?** _____
Alcohol: _____**Yes** _____**No / If yes, how much?** _____
Ever had a problem with alcohol? ___ Yes ___ No (DUI, injury, break-up)
If yes, when did you quit? _____

Where is your worst pain? (Chief Complaint):

_____

_____

Please mark the areas you feel pain on the drawings. Put an "E" if it is external or an "I" if it is internal next to the areas that you have pain. Put an "EI" if the pain is both internal and external.



The information provided by me on this document above is true and current to the best of my knowledge.

Patient Signature:_____ **Date:**_____

Reviewed by:_____ **Date:**_____