The Advanced Spine Center

George S. Naseef, M.D.

Name: _____ Age: ____ Date of Birth: ____ ___ Height: _____ Weight: ___

Marital Status: S M D W Are you currently working? Y N Employer: _____

Is this related to an accident? Auto ☐ Work ☐ Date of Incident:_____

Main Complaints in order of importance: Rate your Pain from 1 to 10: _____

_____ Pharmacy Name: _____

_____ Pharmacy Number: _____

Prior Studies: X-Rays ☐ MRI ☐ CT Scan ☐ EMG/NCV ☐ Bone Scan ☐

Other: _____

Allergies to medication:

_____

_____

_____

Surgery:

	Type:	Year:
1.	_____	_____
2.	_____	_____
3.	_____	_____

Are You Allergic To: ❑ Shell Fish ❑ Contrast Dye ❑ Latex ❑ Nickel ❑ NONE

Medical History:

Heart Disease	☐	Stroke	☐
Hypertension	☐	Seizures	☐
Cancer	☐	Depression	☐
Asthma	☐	Hepatitis, Type___	☐
Diabetes	☐	HIV/AIDS	☐

Other: _____

Other Medical Complaints:

Vision	☐	Blackouts/Fainting	☐
Balance/ Dizziness	☐	Ears/Nose/Throat	☐
Bladder Dysfunction	☐	Bleeding/Clotting	☐
Numbness/ Tingling	☐	Digestion	☐
Bowl Dysfunction	☐	Psychiatric History	☐
Lungs	☐	Headaches	☐
Menopause (female)	☐	Other: _____	

Please check if you:

Smoke: ☐ Packs per day ____ Quit: ☐ When: _____ Alcohol: ☐ Frequency: _____

Current Medications, please provide a Start Date:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

I certify that all of the above is accurate, complete, and without fabrication or suppression.

Signature: _____ Reviewed by:_____