Advanced Pain & Spine Management, S.C.

George I Macrinici, MD
121 S Wilke Rd, Suite 110 Arlington Heights, IL 60005

Name _____Temp: _____ DOB: _____/_____/_____

Address _____

City/State/Zip _____

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Email _____@_____

Do you want access to our Patient Portal? ____Yes _____No (need email address)

I DO/DO NOT (circle one) consent to receive _____voice _____text _____email messages for appointment reminders. Patient signature _____

Do you consent to us having access to your prescription records? _____Yes _____No

Referring Doctor _____ Phone _____

Primary Doctor _____ Phone _____

Preferred Pharmacy _____ Zip Code _____

Address _____ City/State _____

Primary Insurance _____

Cardholder name_____ DOB: _____/_____/_____

Secondary Insurance _____ **OVER →**

OFFICE USE ONLY***

DIAGNOSIS: _____

ORDERS: _____

_____

_____

REFERRALS: _____

MEDICATIONS: _____

_____

Are you currently involved in any litigation regarding your health problems? _____Yes _____No

SOCIAL HISTORY:

1. Do you smoke? ___No ___Yes Cigarettes Cigar Pipe Vaping How much/day? _____
   Past smoker? When Quit _____
2. Do you consume alcohol? ___No ___Yes How often? _____ What? _____
3. Occupation _____
4. Marital status ___ Single ___ Married ___Divorced ___Widow
5. Any children? ___No ___Yes If yes, how many? _____

FAMILY HISTORY:		**MOTHER**	**FATHER**
Any family history of:	Diabetes	_____	_____
	High Blood Pressure	_____	_____
	Asthma	_____	_____
	Heart Disease	_____	_____
	Cancer (type)	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

MEDICAL HISTORY:

Any history (past or present) of:

___ Diabetes	___ High Blood Pressure	___ COPD
___ Heart Disease	___ Asthma	___ Seizures
___ Osteoarthritis	___ Rheumatoid Arthritis	___Drug Abuse
___ Alcohol Abuse	___ Sexual Abuse	___ Kidney Disease
___ Mental Illness	___ Depression	___ Anxiety

___ Cancer (details _____

Have you ever had a blood transfusion? ___ No ___ Yes

Do you take any blood THINNERS? ___ No ___ Yes If yes, name_____

Have you had any major surgeries? _____

_____

_____

Do you have any allergies to medications? ___ No ___ Yes Please list: _____

_____

Are you allergic to any of the following: _____ No

_____ Latex _____ Steroids _____ Dye _____ Adhesives (band-aids)

_____ Lidocaine/Marcaine/Bupivicaine/Novocaine

Do you have any of the following symptoms?

___ Chills
___ Fatigue
___ Fever
___ Night sweats
___ Recent weight change
___ Ear pain
___ Hearing problems
___ Tinnitus
___ Epistaxis (frequent nose bleeds)
___ Nasal congestion
___ Rhinorrhea (frequent runny nose)
___ Sore throat
___ Blurred vision
___ Eye pain
___ Sensitivity to light
___ Glasses/Contacts
___ Cough
___ Shortness of breath
___ Wheezing

___ Abdominal pain
___ Constipation
___ Diarrhea
___ Nausea
___ Vomiting
___ Heartburn/indigestion
___ Painful urination
___ Blood in urine
___ Urinating during night 2+times
___ Frequent urination (daytime)
___ Eczema
___ Psoriasis
___ Jaundice
___ Rashes
___Excessively dry skin
___ Chest pain
___ Palpitations
___ Tachycardia
___ Dizziness

___ Fainting
___ Memory loss
___ Numbness/tingling
___ Weakness
___ Paralysis
___ Seizures
___ Tremors
___ Vertigo
___ Headaches
___ Migraines
___ Neck/shoulder pain
___ Easy bruising
___ Excessive bleeding
___ Swelling of hands/feet
___ Joint swelling
___ Joint pain
___ Difficulty walking 2 blocks
___ Excessive thirst
___ Feeling stressed

Tell me about your pain:

___ Muscular ___ Achy ___ Throbbing ___ Burning ___ Sharp ___ Stabbing ___ Painful to touch

MEDICATION LIST (please list all medications/dosages you currently take)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

OFFICE USE ONLY

Height _____ Weight _____ Pain Level _____/10 BP _____/_____ HR _____ spO2 _____%

CC: _____

_____

_____

_____

_____

_____