PATIENT HISTORY

Kanuru Interventional Spine & Pain Institute Ramesh P. Kanuru, MD FACA

Ramesh P. Kanuru, MD FACA
Board Certified in Pain Management

Patient Name: DOB: Age: Sex: HT: WT:	Please provide identifying information, then answer ALL the following questions, about your health.								
2. Do you have any ALLERGIES to medicines or to latex rubber? NO YES 3. Smoking: Never Current Former 4. Alcohol: Never Current Occasionally 5. Illicit Drug Usage: Yes No	Patient	Name:							
2. Do you have any ALLERGIES to medicines or to latex rubber? NO YES 3. Smoking: Never Current Former 4. Alcohol: Never Current Occasionally 5. Illicit Drug Usage: Yes No	4.								
3. Smoking:NeverCurrent Former 4. Alcohol:NeverCurrent Occasionally 5. Illicit Drug Usage:YesNo	1,	Were you injured at work or in a motor vehicle accident? NO YES							
4. Alcohol: Never Current Occasionally 5. Illicit Drug Usage: Yes No	2.	Do you have any	ALLERGIES to me	dicines	or to late	rubber?	NO YI	ES	
4. Alcohol: Never Current Occasionally 5. Illicit Drug Usage: Yes No	(pA								
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5. Illicit Drug Usage:No	3.	Smoking:	Never	Cu	rrent	Former			
	4.								
6. Please list all SURGERIES	5.								
									· · · · · · · · · · · · · · · · · · ·
7. Please list the other doctors you have seen for this condition:									
Specialty Name		Specialty		Na	me				
Spine Surgeon	Spine Surgeon								
Neurologist	Neurologist				***************************************				
Orthopedic Surgeon	Orthopedic Surgeon								
Primary Care Physician	Primar	y Care Physician							

Highland Office 3445 Ridge Road Highland, IN 46322 Phone: (219) 838-1100 Pinnacle Hospital 9301 Connecticut Drive Merrillville, IN 46307 Fax: (219) 923-3501

www.painkanuru.com

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8. Circle the treatments you have used in the past and the relief it provided:

Treatment	When	Type	How much relief? (Significant, Moderate, Minimal, No relief)
Physical Therapy			
Brace (neck/back/knee)			
Steroid Injections			
Anti-Inflammatories			
Muscle Relaxer			
Pain Medication			
Other			

OTC Medications

NAME OF MEDICATION	DOSE	FREQUENCY
And the second		
Signature:	Date:	

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REVIEW OF SYSTEMS

Please check all symptoms that you currently have.

CONSTITUTIONAL	MUSCULOSKELETAL	HEART/CARDIAC	NEUROLOGICAL	
Change in appetite	Arthralgia Myalgia	Chest pain Palpitation	Headache Dizziness	
Change in weight	Neck Pain Back Pain	PND Edema	Syncope Muscle spasm	
Fever	Joint Stiffness Joint swelling	Varicosities DOE	Seizure Paresthesia	
Chills	Ambulatory Difficulties	Orthopnea Syncope	Memory Loss	
Malaise	Joint Pain	Dizzy spells	Ataxia	
Fatigue		10 10	Altered Speech	
GENITOURINARY	GASTROINTESTINAL	SKIN	PSYCHIATRIC	
Dysuria Hesitancy	Change in appetite	Itching	Depression	
Urgency Frequency	Nausea Vomiting	Redness	Delusions	
Nocturia Hematuria	Hematemesis Diarrhea	Rash	Hallucinations	
Incontinence Dyspareunia	Constipation Heartburn	Ulcers	Mood Swings	
Vaginal Discharge	Bloating	Sun exposure	Anxiety	
Irregular menses	Abdominal Pain	Hair loss	Insomnia	
Dysmenorrhea Heavy menses	Blood in stool			
Itching Pelvic Pain				
HEMATOLIGIC/LYMPHATIC	ENDOCRINE	RESPIRATORY	IMMUNOLOGIC	
Anemia	Weight Gain	Dry cough	Hives	
Bleeding tendency	Weight loss	Coughing up mucus	Itching	
Easy Bruising	Intolerance to temperature	Hemoptysis	Frequent infections	
Swollen Glands	Fingernail changes	Wheezing	Difficulty healing	
	Excessive thirst	Shortness of breath		
	Changes in sexual desire	Pain with breathing		
HEENT	BREAST	EYES		
Tinnitus	Breast lump	Redness		
Diminished hearing	Discharge from nipples	Discharge		
Loss of hearing Runny nose	Change in nipples	Irritation		
Loss of smell Nose bleeds	100 M	Eye Pain		
Sinusitis Post Nasal drip		Blurred Vision		
Bleeding gums Loss of taste		Diminished Vision		
Sore throat Change in voice		Loss of vision		
Dysphagia				

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