

Saint Luke's South
Overland Park, KS 66213
Initial Patient History

(Please fill out this form and bring it with you to your appointment.)

Name _____ Date _____ Date of birth _____

Age _____ Sex: M ___ F ___ Height: _____ ft. _____ in. Weight _____ lbs

Referring Physician _____ Primary Physician _____

List all other physicians involved in your care and their specialty. _____

Have you had any of the following?

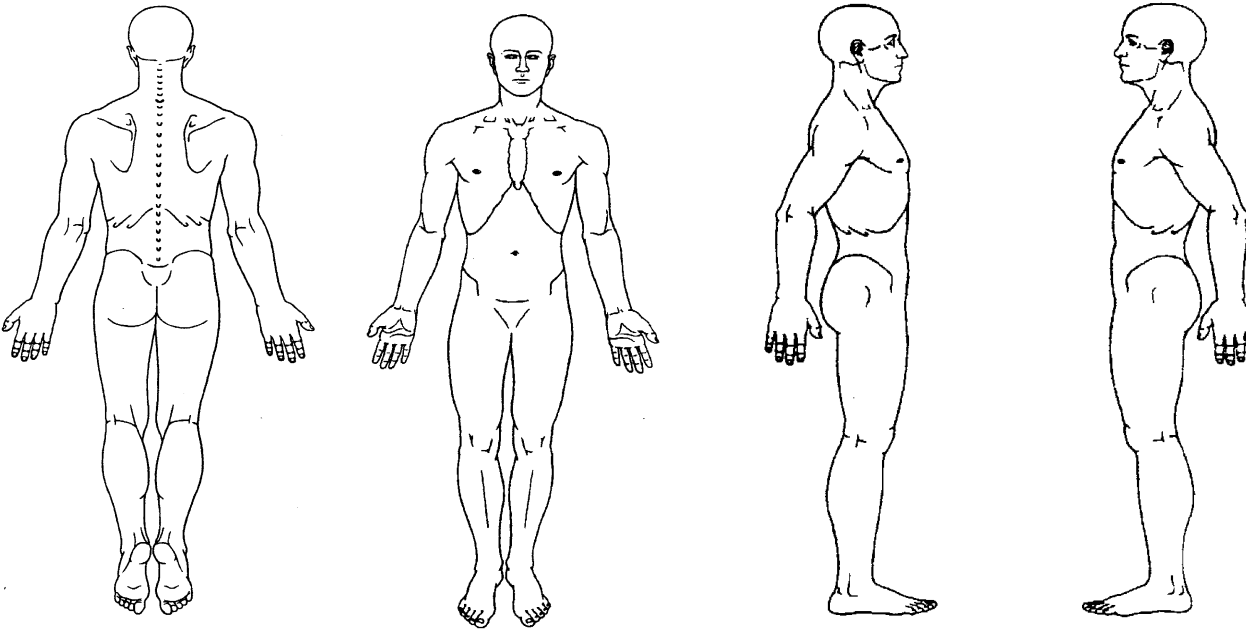
MRI Yes ___ No ___ Date _____ Where _____

EMG Yes ___ No ___ Date _____ Where _____

CT SCAN Yes ___ No ___ Date _____ Where _____

Myelogram Yes ___ No ___ Date _____ Where _____

Please draw where your pain primarily located? (Please use following diagram.)



When did the pain begin? _____ Is the pain getting worse _____, or better _____?

Did it begin gradually or suddenly? _____

If suddenly, is it the result of an injury? _____

Describe the injury. _____

Is it getting worse or has it improved? _____

Patient Imprint: