**William S. Reid, Jr., M.D.**

**Neurological Surgery**

**Minimally Invasive Spine Surgery**

1932 Alcoa Hwy., Suite 280 • Knoxville, Tennessee 37920

Phone 865-329-4003 • Fax 865-329-4043 • www.tnbrainandspine.com

- Associate Clinical Professor of Neurosurgery, UTMCK
- Clinical Director, Center for Minimally Invasive Spine Surgery
- Board Certified, Neurological Surgery

**Caroline Chermely,** FNP, BC

Patient Name:______________________________________________________________

Appointment Date and Time: ____________________________________________________

_____ UT Medical Center
1932 Alcoa Highway
Building C, Suite 280
Knoxville, TN 37920

_____ East TN Medical Group
266 Joule Street
Alcoa, TN 37701

Thank you for scheduling an appointment. We ask that you complete the attached forms, front and back, and bring them with you to your appointment.

We also ask that if you have had an MRI, CT scan or x-rays taken for the reason you are seeing our physician at a facility other than UT Medical Center, please bring these films with you. Not doing so will result in having to reschedule your appointment.

Payment of co-pays and coinsurance is expected at the time of service unless arrangements are made in advance of your appointment. Please contact our patient accounts department at 329-4003 if you anticipate a problem making this payment.

If you are seeing our physician as the result of an accident, please call our office prior to this visit.

If you need assistance locating our office or have questions regarding your upcoming appointment, please contact our office at 329-4003.

We look forward to seeing you.

See reverse

# William S. Reid, Jr., M.D.
## Patient Health History

Referring MD: ____________________

PCP: ____________________

Chart #: ____________________

***CHIEF COMPLAINT:***

Patient Name: ________________________________Date of Birth: ______________ Age: ____________

Reason for visit? ________________________________________________

Do you have leg pain?_______ Right____ Left____ Both____ Do you have arm pain?_______ Right____ Left___ Both____

Do you have weakness:_______ Where?_________________ Do you have numbness?_______ Where?_________________

Was this problem the result of: __ Car Accident __ Work Accident __ Other Accident __ No

Date of accident or first appearance of symptoms: ________________________________

Please describe treatments received for this problem: ________________________________

Have you had: Physical Therapy_______ Oral steroids_______ Steroid Injections_______

Have you been disabled from working? ____ yes _____ no "If yes, beginning on what date?" ____________

List any x-rays, MRI, CT or other tests you have had related to this injury / illness: ________________________

________________________________________________

## *Current Illnesses & Treatment:*

1) ________________________________________________

2)________________________________________________

3) ________________________________________________

4) ________________________________________________

5) ________________________________________________

Are you: _______ Right handed? _______ Left handed? Ht: _________ Wt: _________ BP: ________/_________

| Surgeries/Hospitalizations | Year | Complications | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| **Current Medication(s)** | **Dose** | **Frequency** | **Prescribing Physician** |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

List all drug allergies: ________________________________ ________________________________

________________________________ ________________________________

Are you allergic to latex?_________

## Family History

☞

| Family Member | Alive | Deceased | Age | Health Status or Cause of Death |
|---|---|---|---|---|
| Grandmother (mom's) | | | | |
| Grandfather (mom's) | | | | |
| Grandmother (dad's) | | | | |
| Grandfather (dad's) | | | | |
| Mother | | | | |
| Father | | | | |
| Sister/Brother | | | | |
| Sister/Brother | | | | |
| Sister/Brother | | | | |
| Sister/Brother | | | | |

## Social History

☞ Occupation: ____________________ ☛ Do you have children? ☐ Yes ☐ No How many? __________

☞ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

☞ Do you live alone? ☐ Yes ☐ No

☞ Do you smoke? ☐ No ☐ Yes, I've smoked ____ packs per day for _____ years

☐ No, I quit ____ years ago. At that time I smoked _____ packs per day

☞ Do you drink alcohol? ☐ No ☐ Yes If yes, please estimate amount: ____________________

## Review of Systems

☞ Are you currently, or have you had, problems with:

| Constitutional | Circle One | |
|---|---|---|
| Fever | Yes | No |
| Weight Loss | Yes | No |
| Excessive Fatigue | Yes | No |
| Night Sweats | Yes | No |
| **Eyes** | | |
| Wear Glasses (Date of last exam: _______) | Yes | No |
| Infections | Yes | No |
| Injuries | Yes | No |
| Glaucoma | Yes | No |
| Cataracts | Yes | No |
| **Cardiovascular** | | |
| Chest Pain | Yes | No |
| High Blood Pressure | Yes | No |
| Irregular Pulse | Yes | No |
| Heart Murmur | Yes | No |
| High Cholesterol | Yes | No |
| Swelling in Feet or Hands | Yes | No |
| Leg Pain While Walking | Yes | No |

| Ear, Nose, Throat and Mouth | Circle One | |
|---|---|---|
| Wear hearing aids | Yes | No |
| Hearing Loss | Yes | No |
| Ear Pain | Yes | No |
| Ear Infections | Yes | No |
| Ringing in Ears: Left Right Both | Yes | No |
| Dizziness | Yes | No |
| Nosebleeds | Yes | No |
| Nasal Congestion | Yes | No |
| Nasal Drainage | Yes | No |
| Inability to Smell | Yes | No |
| Sinus Problems | Yes | No |
| Sinus Headaches | Yes | No |
| Sore Throats | Yes | No |
| Mouth Sores | Yes | No |

| Respiratory | | |
|---|---|---|
| Asthma | Yes | No |
| Chronic Cough | Yes | No |
| Emphysema | Yes | No |
| Shortness of Breath | Yes | No |
| Bronchitis | Yes | No |
| Pheumonia | Yes | No |
| Lung Cancer | Yes | No |
| Bloody Sputum | Yes | No |
| **Genitourinary** | | |
| Urinary Tract Infections | Yes | No |
| Painful Urination | Yes | No |
| Blood in Your Urine | Yes | No |
| Difficulty Starting or Stopping Stream | Yes | No |
| Incontinence | Yes | No |
| Kidney Stones | Yes | No |
| Prostate Cancer (males) | Yes | No |
| Endometriosis (females) | Yes | No |
| Uterine or Cervical Cancer (females) | Yes | No |
| **Neurological** | | |
| Fainting Spells | Yes | No |
| Seizures | Yes | No |
| Problems with Your Memory | Yes | No |
| Disorientation | Yes | No |
| Difficulty with Your Speech | Yes | No |
| Inability to Concentrate | Yes | No |
| Double or Blurred Vision | Yes | No |
| Face Weakness | Yes | No |
| Coordination in Arm and/or Legs | Yes | No |
| **Hematologic/Lymphatic** | | |
| Anemia | Yes | No |
| Hemophilia | Yes | No |
| Bleeding Tendencies | Yes | No |
| Persistent Swollen Glands | Yes | No |
| **Psychiatric** | | |
| Anxiety | Yes | No |
| Depression | Yes | No |

| Gastrointestinal | | |
|---|---|---|
| Indigestion or Pain With Eating | Yes | No |
| Nausea | Yes | No |
| Vomiting | Yes | No |
| Blood in Your Vomit | Yes | No |
| Liver Disease | Yes | No |
| Jaundice | Yes | No |
| Abdominal Pain | Yes | No |
| Change in Your Bowel Habits | Yes | No |
| Ulcers or Gastritis | Yes | No |
| Colon Cancer | Yes | No |
| **Musculoskeletal** | | |
| Broken Bones | Yes | No |
| Arm or Leg Weakness | Yes | No |
| Back Pain | Yes | No |
| Arm or Leg Pain | Yes | No |
| Joint Pain or Swelling | Yes | No |
| Arthritis | Yes | No |
| **Integumentary** | | |
| Skin Disease | Yes | No |
| Skin Cancer | Yes | No |
| Breast Pain, Tenderness/Swelling (fem) | Yes | No |
| Nipple Discharge (females) | Yes | No |
| **Endocrine** | | |
| Diabetes | Yes | No |
| Thyroid Disease | Yes | No |
| Increased Appetite | Yes | No |
| Excessive Thirst or Urination | Yes | No |
| Hormone Problems | Yes | No |
| **Allergic/Immunologic** | | |
| Food Allergies | Yes | No |
| Nasal Allergies | Yes | No |
| Immunologic Disorders | Yes | No |

☞ The above information is accurate to the best of my knowledge.

Patient Signature ____________________ Date ____________

Physician's Signature Following Review w/Patient ____________________ Date ____________

Physician's Signature Following Review w/Patient ____________________ Date ____________

Physician's Signature Following Review w/Patient ____________________ Date ____________