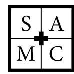
NeuroSpine Center



Health History

Name: ______________________________ Date of Birth: ______________ Age: ________

Referring Physician: __________________________ Occupation______________________

Chief complaint or reason for today's visit? ________________________________

Have you had this problem before? ________________ How long have you had this problem? __________

Explain: ____

Were you hospitalized for this problem?______________ Is there an attorney involved? ______________

Workers' Comp? _______ Auto Accident? ______ Home Accident? ______ Other? ________ Act of Crime? ________

Past Medical/Family History:

Check the ❏ if ***you*** have had any of the following; check the O if a ***close blood relative*** has had any of the following:

- ❏ O Alcohoslism, Drug Abuse
- ❏ O Depression, Suicide Attempt or Nervous Breakdown
- ❏ O Anemia
- ❏ O Bleeds easily/Bleeding Disorder
- ❏ O Diabetes
- ❏ O Thyroid Disease
- ❏ O Eczema, Hives, Rashes
- ❏ O Kidney Disease
- ❏ O Prostate Disease (BPH)
- ❏ O Lung Disease, Asthma, Emphysema
- ❏ O Infections (HIV, Other ___________________)
- ❏ O Pneumonia, Tuberculosis
- ❏ O Epilepsy, Seizures
- ❏ O Eye problems -- Cataracts/Glaucoma
- ❏ O High Blood pressure
- ❏ O Heart Disease, Murmur or Rheumatic Fever
- ❏ O Stroke, Brain Bleed, Aneurysm, Brain Tumor
- ❏ O Liver disease, hepatitis, Yellow Jaundice
- ❏ O Cancer (type _________________________)
- ❏ O Ulcer in stomach
- ❏ O Arthritis -- Osteo/Rheumatoid
- ❏ O Lupus, Raynauds, Sjogrens, Fibromyalgia

Other Past History:

Please list any other major illnesses and/or injuries:

____

____

Surgeries/Hospitalizations, Year and any Complications:

____

____

____

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____

Have you or a family member ever had problems with anesthesia?	❏ Yes	❏ No
Do you have a pacemaker?	❏ Yes	❏ No
Are you claustrophobic?	❏ Yes	❏ No
Are you pregnant?	❏ Yes	❏ No
Is there any metal in your body (plates, screws, etc.)?	❏ Yes	❏ No

Current Medications, Dose and Frequency: ______________________

____

____

Current Medications, Dose and Frequency: ______________________

____

____

Allergies/Reactions to Medications, Anesthetics or Materials: ______________________

____

Your Preferred Pharmacy: ______________________ City: ______________ Phone: ____________

Social History:

Occupation: ______________________

Do you smoke?

❑ Yes, I've smoked ______ packs of cigarettes per day for ______ years.

❑ No, I have never smoked.

❑ No, I quit _____ years ago. At that time, I smoked ______ packs per day for ______ years.

Do you drink alcohol? ❑ No ❑ Yes ❑ Rarely ❑ 1 or more times a week ❑ Daily

Review of Systems:

Height: ______________ Weight: ______________ Marital Status: ______________

Are you currently or have you had problems with:

Constitutional:	***(Circle Yes or No)***		**Neurological:**	***(Circle Yes or No)***	
Weight Gain	Yes	No	Numbness	Yes	No
Weight Loss	Yes	No	Weakness	Yes	No
Night Sweats	Yes	No	Headaches	Yes	No
Insomnia	Yes	No	Speech Problems	Yes	No
Excessively Tired	Yes	No	Loss of Balance	Yes	No
			Loss of Memory	Yes	No
Skeletal:			**Skin:**		
Arthritis	Yes	No	Rash	Yes	No
Loss of Motion	Yes	No	Lesions/Ulcers	Yes	No
Fractures	Yes	No			
Joint Pain	Yes	No			
Joint Swelling	Yes	No			
Endocrine:			**Psychiatric:**		
Increased Thirst	Yes	No	Depression	Yes	No
Hair Changes	Yes	No	Sleep Problems	Yes	No
Hot/Cold Spells	Yes	No	Mood Swings	Yes	No
Eyes:			**Allergic/Immunologic:**		
Double Vision	Yes	No	Sneezing	Yes	No
Visual Loss	Yes	No	Itchy Eyes/nose	Yes	No
Visual Changes	Yes	No	Itchy Throat	Yes	No
Insomnia	Yes	No	Skin Rash	Yes	No
Excessively Tired	Yes	No			
Ear, Nose, Throat and Mouth:			**Gastrointestinal:**		
Hearing Loss	Yes	No	Indigestion or Heartburn	Yes	No
Noise/Ringing in Ears	Yes	No	Diarrhea	Yes	No
Nasal Congestion	Yes	No	Constipation	Yes	No
Nasal Drainage	Yes	No	Loss of Appetite	Yes	No
Sore Throat	Yes	No	Blood in Stool	Yes	No
Hoarseness	Yes	No	Black, Tarry Stool	Yes	No
Dizziness	Yes	No			
Cardiovascular:			**Respiratory:**		
Chest pain or Angina	Yes	No	Coughing up Blood	Yes	No
Irregular Beats	Yes	No	Trouble Breathing at Night	Yes	No
Shortness of Breath	Yes	No	Snoring	Yes	No
Swelling in Legs	Yes	No	Shortness of Breath	Yes	No
Urinary:			**Blood:**		
Bladdar Trouble	Yes	No	Abnormal Bleeding	Yes	No
Incontinence	Yes	No	Blood Clots	Yes	No

I have reviewed the above information with the patient.

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Physician Signature **Date**

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

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Patient Signature **Date**