



**Spine Center
Patient Health History Questionnaire**

In preparation for your upcoming appointment in the Spine Center, please take a few minutes to complete the following health history. Completion of this medical form in advance of your Spine Center appointment will help us provide the best possible care for your Spine condition.

Kindly remember to bring this completed medical form with you at the time of your appointment. Please give the completed form to the clinic staff person upon your placement in an examination room. You do not need to mail this form in advance.

Thank you.

PATIENT INFORMATION

Name: _____

Date of Birth: ___/___/____
mo day year

Male Female Height: _____ Weight: _____

VISIT INFORMATION

Date of Visit: ___/___/____
mo day year

Referred by: Referring Physician Name: _____

Self-referred

1. Who is your regular / primary care doctor or nurse? _____

2. Reason for visit: (what is your problem?) _____

3. Is this a work-related injury? No Yes; If yes, date of Injury ___/___/____
mo day year

4. Where do you/did you work? _____

Type of Work: _____ Student

Please note any work modifications, such as light duty, part-time or other:

If not working, date last worked: ___/___/____
mo day year

5. Is this an injury resulting from a non-work-related accident? No Yes

6. When did this episode of your symptoms/problem begin? Date: ___/___/___
mo day year

7. If known, please describe how your symptoms/problem began: _____

8. How long have you had spine problems? _____

9. For this problem have you had:

Physical Therapy No Yes, when? _____

Spinal Injections No Yes, when? _____

MEDICATIONS

Please list ALL the medications you are currently taking (include prescription, over-the counter non-prescription, herbs and vitamins). Please include the dose (strength), and how often you take it.

Name of Medication	Reason for taking	Dose	How often/when
<i>Example: Synthroid</i>	<i>Thyroid disorder</i>	<i>0.15mg</i>	<i>One time a day</i>

Are you currently on any blood thinning medication such as Coumadin, Warfarin, Heparin, Fragmin, Lovenox, Pletal, Aspirin? No Yes
Since When? _____ reason why? _____

ALLERGIES

Do you have allergies or sensitivities to any medicines, latex, food, or dye/contrast material?

No Yes If YES, please list what you are allergic to, and what happened when you took it.

Allergy (Medication/Latex/food/contrast dye)	Type of Reaction

MEDICAL CONDITIONS

List below all the medical problems you have (for example: depression, heart or lung problems, high blood pressure, diabetes, fibromyalgia, ulcers, cancer, etc.).

Medical Problem	Date Problem Began

Have you ever had phlebitis, blood clots, or an embolism? _____

SURGERY

List below all surgeries/operations you have had and their dates.

Surgical Procedure	Date of Surgery

OTHER HEALTH FACTORS

1. Do you currently smoke? No Yes
 If yes, how many packs per day? ____ For how many years? ____
 If you are not currently smoking, have you smoked in the past? No Yes

2. Do you drink alcohol (this includes beer, wine, and/or hard liquor)? No Yes

If yes, how much? _____

3. Do you need assistance with your daily activities? No Yes

4. Do you use any of the following? Cane Walker Crutches Wheelchair

5. What do you expect from your Spine Center visit? _____

FAMILY MEDICAL HISTORY

Has any relative ever had any of the following medical problems or conditions? If yes, please indicate the relationship to you (grandparent, parent, brother or sister, etc.).

Diabetes

Cancer

Heart problems

Spine problems

Deep vein thrombosis
(blood clots)

Arthritis

High Blood Pressure

Stroke

Congenital deformities

Obesity

Asthma

Osteoporosis

Frequent infections

Tuberculosis

Other

REVIEW OF SYSTEMS (To be completed by Spine Center health care provider)

Constitutional _____

Eyes _____

Cardiovasc _____

Resp _____

Heme/Lymph _____

ENT _____

GI _____

GU _____

Musculo _____

All/Imune _____

Skin _____

Neuro _____

Psych _____

Endo _____

All others neg. _____

Patient Signature/Date

Reviewed by/Date

WAA/dmg 6/06