

PATIENT HEALTH HISTORY: Please Complete **Front** and **Back** of This Form

Patient Name: Birth Date: Occupation:

Marital Status: Age:

Have you seen another Neurosurgeon or Orthopedic Surgeon for this condition? _ Yes _ No

Y/N	Treatments	Length of Treatment, Results	Y/N	Diagnostic Tests	Results
	Traction			Spine X-Ray	
	Physical Therapy			MRI	
	Bed rest			CT Scan	
	Acupuncture			Bone Scan	
	Chiropractic Tx			EMG	
	Pain Medication			Myelogram	
	Anti-Inflam Meds			Neurologists:	
	Spinal Injections			Pain Management Doctor:	

What is your reason for the visit? _____

Current problem due to: _____ Date of Injury: _____

Describe: _____

Year	Surgery	Outcome/Complications

Year	Surgery	Outcome/Complications

Please list any prior major illnesses and/or injuries: _____

Have you ever had problems with anesthesia? _____, describe _____

Do you have a Latex Allergy? _____, describe _____

Pharmacy Name:

Pharmacy Phone Number:

Medications, Vitamins, Supplements	Dose	Frequency of dose

List Allergies	Allergic Reaction

Relation	Age	Conditions/Alive or Expired	Relation	Age	Conditions/Alive or Expired
Father			Mother		
Brother			Sister		
Brother			Sister		
Son			Daughter		
Son			Daughter		

Y/N	Social Behavior	Amount/Frequency
	Tobacco- Cigs, Cigar, Pipe	
	Tobacco- Chew, Snuff	
	Alcohol	

Y/N	Social Behavior	Amount/Frequency
	Exercise	
	Use of Illegal Substances	
	Caffeine- Coffee/Soda/Tee	

Review of Systems: Please complete **Front** and **Back** of this Form

Check box associated with current problems and record physicians name under specialty when applicable

Allergic/Immunologic

- Food Allergies: _____
- Immunologic Disorders
- Inhalant (nasal) Allergies

Cardiovascular

Cardiologists: _____

- Angina
- Chest Pain
- Heart Murmur
- High Blood Pressure
- High Cholesterol
- Irregular Pulse
- Leg Pain While Walking
- Swelling in Feet
- Swelling in Hands
- Excessive Fatigue
- Fever
- Loss of sleep
- Weight Loss: Intentional or Unintentional (circle)

Ear, Nose, Throat and Mouth

- Ear Infections
- Hearing Loss
- Inability to Smell
- Nose Bleeds
- Ringing in Ears
- Sinus Problems
- Vertigo/Dizziness
- Wear Hearing Aids

Endocrine

- Diabetes
- Excessive Thirst
- Excessive Urination
- Hormone Problems
- Thyroid Disease

Eyes

- Cataracts: Right / Left (circle)
- Double vision
- Glaucoma
- Wear Glasses

Gastrointestinal

GI Doctor: _____

- Abdominal Pain
- Jaundice
- Liver Disease
- Nausea
- Vomiting

Genitourinary

- Blood In Urine
- Difficulty Starting
- Difficulty Stopping
- Endometriosis
- Incontinence
- Painful Urination
- Sexual Dysfunction: _____
- Urinary Tract Infections

Hematologic/Lymphatic

Oncologist: _____

- Anemia
- Bleeding Tendencies
- Blood Transfusion
- Cancer
- Hepatitis C
- Psoriasis
- Skin: Rash, Dry, Itchy, Scaly (circle)

Musculoskeletal

- Arm Pain
- Arm Weakness
- Back Pain
- Joint Pain
- Joint Swelling
- Leg Pain
- Leg Weakness

Neurological

- Blacking out
- Blurred Vision
- Fainting Spells
- Forgetfulness
- Imbalance
- Inability to Concentrate
- Numbness
- Tingling

Psychiatric

- Anxiety
- Depression
- Panic Disorders
- Suicidal Thoughts

Respiratory

Pulmonologist: _____

- Asthma
- Cough
- Emphysema
- Shortness of Breath

The information recorded on the front and back of this form is accurate to the best of my knowledge.

Patient Signature: _____

Date: _____

Reviewed by: _____

Date: _____