Neurological and Spinal Surgery, LLC
Health History Form

NAME__________________________ **PRIMARY DR.** ______________________

Age__________ Height__________ Weight__________ Date__________

Onset of Symptoms/Date of Injury______________Injury is [ ] Work [ ] Fall [ ] Auto Accident

Litigation Involved? [ ] Yes [ ] No Is this a Work Comp case? [ ] Yes [ ] No

Employer__________________________ Work Phone________________

Occupation__________________________ How Long?________________

Are you Currently working? [ ] Yes [ ] No [ ] Retired Date you stopped working__________

Have you had previous Spine surgery? [ ] Yes [ ] No If yes, when?__________Surgeon?__________

Is this the same area of concern now? [ ] Yes [ ] No

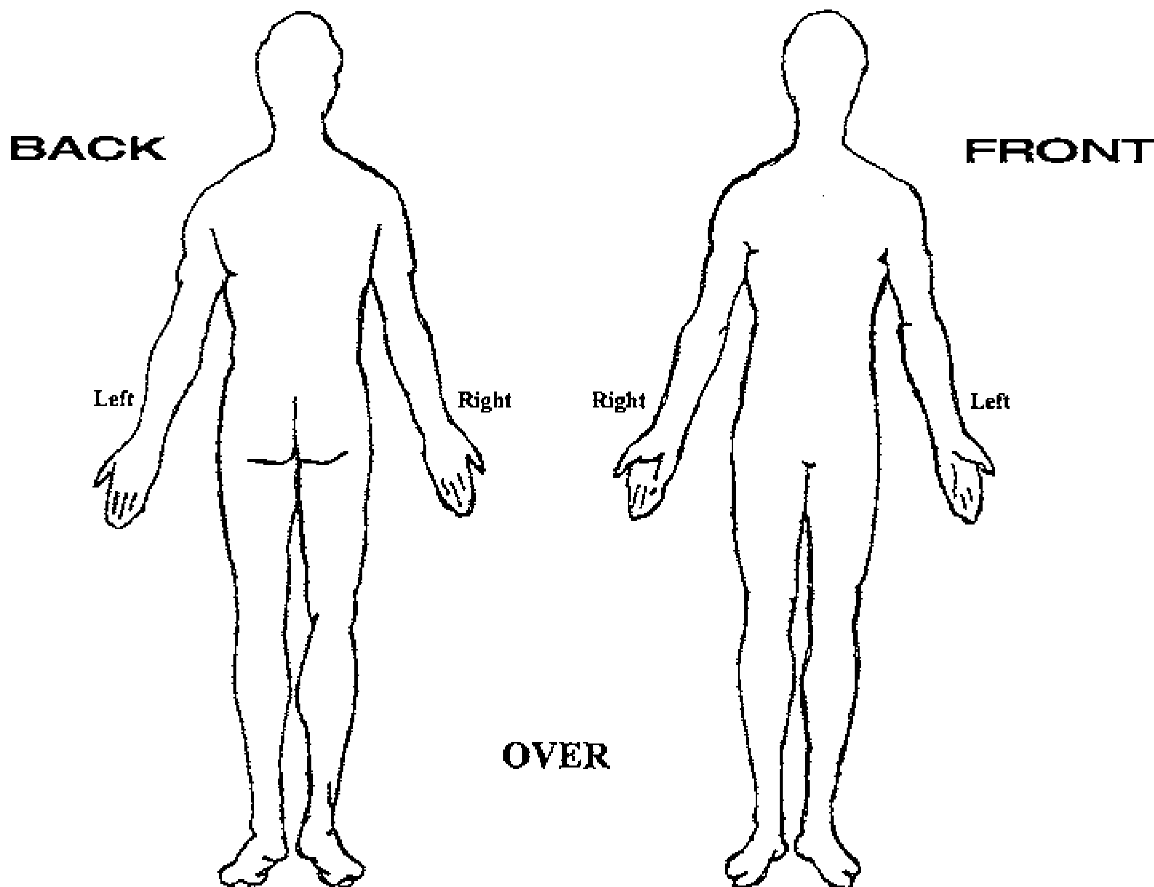
Rate your Pain (0 = no pain, 10 = worst pain you can imagine)

Right now:	0	1	2	3	4	5	6	7	8	9	10
At worst:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10

Pain occurs: [ ] Intermittent [ ] Constant [ ] Daily

Use this diagram to show where your pain is located and the type of pain you feel at the present time.

Burning xxx Stabbing /// Numbness --- Deep Ache zzz Pins and Needles ooo



OVER

Form 22

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How do the following affect your pain?

	Better	Worse	No Change
Bed Rest	[ ]	[ ]	[ ]
Bending	[ ]	[ ]	[ ]
Changing Positions	[ ]	[ ]	[ ]
Coughing/Sneezing	[ ]	[ ]	[ ]
Exercising	[ ]	[ ]	[ ]
Golfing	[ ]	[ ]	[ ]
Heat	[ ]	[ ]	[ ]
Ice	[ ]	[ ]	[ ]
Lifting	[ ]	[ ]	[ ]
Lying Down	[ ]	[ ]	[ ]
Pushing	[ ]	[ ]	[ ]
Riding in a Car	[ ]	[ ]	[ ]
Sitting	[ ]	[ ]	[ ]
Squatting	[ ]	[ ]	[ ]
Stairs	[ ]	[ ]	[ ]
Standing	[ ]	[ ]	[ ]
Stress	[ ]	[ ]	[ ]
Walking	[ ]	[ ]	[ ]
Working	[ ]	[ ]	[ ]
Other__________	[ ]	[ ]	[ ]

Treatments Tried

	Did It Help?	
[ ] Pain Clinic	[ ] Yes	[ ] No
[ ] Brace	[ ] Yes	[ ] No
[ ] Chiropractor	[ ] Yes	[ ] No
[ ] Injections		
[ ] Epidural	[ ] Yes	[ ] No
[ ] Trigger Point	[ ] Yes	[ ] No
[ ] SI Joint	[ ] Yes	[ ] No
[ ] Facet	[ ] Yes	[ ] No
[ ] Physical Therapy	[ ] Yes	[ ] No
[ ] Acupuncture	[ ] Yes	[ ] No

*** If checked "yes" above list start date, duration, location of treatment and number of visits.**

____

____

Medications Tried for Spine Pain & Duration

____

____

____

____

PAST MEDICAL HISTORY

Cardiac (Heart)
- [ ] **NONE**
- [ ] Heart Attack
- [ ] Chest Pain
- [ ] Hypertension/High Blood Pressure
- [ ] Shortness of Breath
- [ ] Irregular Heart Rate
- [ ] High Cholesterol
- [ ] Valve Problems: Prolapse
  Murmurs
- [ ] Other

Pulmonary (Lung)
- [ ] **NONE**
- [ ] Asthma
- [ ] Emphysema/COPD
- [ ] Bronchitis
- [ ] Chronic Cough
- [ ] Pneumonia
- [ ] Other

Hematologic (Blood)
- [ ] **NONE**
- [ ] Anemia
- [ ] Clotting Problems
- [ ] Easy Bruising
- [ ] Other

Gastrointestinal/Hepatic
- [ ] **NONE**
- [ ] Ulcers
- [ ] Gallbladder Problems
- [ ] Hepatitis A, B, or C
- [ ] Liver Disease
- [ ] Diarrhea
- [ ] IBS
- [ ] GERD
- [ ] Other

Other Medical Problems
- [ ] **NONE**
- [ ] Thyroid Problems
- [ ] Cancer If Yes, where_____
- [ ] HIV/AIDS
- [ ] Depression
- [ ] Mental Illness
- [ ] Skin Problems
- [ ] Gout
- [ ] Eye Problems
- [ ] Ear, Nose, Throat Problems
- [ ] Transfusion
- [ ] Diabetes
- [ ] Rheumatoid Arthritis
- [ ] Other_______________

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PAST MEDICAL HISTORY CONTINUED **DATE OF BIRTH**_______________

Renal (Kidney/Bladder)
[ ] **NONE**
[ ] Kidney Stones
[ ] Chronic Infections
[ ] Dialysis
[ ] Kidney Failure
[ ] Prostate Problems
[ ] Other

Neurologic Disease
[ ] **NONE**
[ ] Epilepsy/Seizures
[ ] Stroke/TIA
[ ] Parkinson's
[ ] MS
[ ] Dizzy/Fainting Spells
[ ] Headaches
[ ] Other

Cancer
Type____________________
Treatment____________________
Physician____________________
Remission (Status)____________

☐ **NONE** **PAST SURGERIES**

TYPE	YEAR	TYPE	YEAR

☐ **NONE** **MEDICATIONS**

NAME	DOSE	NAME	DOSE

(Please include Aspirin, over the counter medications, or herbal supplements)

☐ **NONE** **ALLERGIES**

MEDICATION	REACTION	MEDICATION	REACTION

Iodine/Shellfish Allergy__________________. What is the reaction? __________________

OVER

FAMILY HISTORY

	Alive?	Brother/Sister		Age OR age at death	Major Diseases (i.e. stroke, cancer, heart disease, diabetes)
Mother	[ ] Yes [ ] No	____	____	______	______________
Father	[ ] Yes [ ] No	____	____	______	______________
Siblings	[ ] Yes [ ] No	____	____	______	______________
	[ ] Yes [ ] No	____	____	______	______________
	[ ] Yes [ ] No	____	____	______	______________

SOCIAL HISTORY

Marital Status

[ ] Single [ ] Married [ ] Divorced [ ] Widowed Number of Children __________

Do You Use Nicotine Products?

[ ] No, Never Have

[ ] No, I stopped in __________

How much did you use?__________packs/cans/cigars per day for__________years

[ ] Yes, I do

__________packs/cans/cigars per day for__________years

Caffeine Use [ ] None

[ ] If so: What kind__________________ How many ounces per day______

Alcohol Use

[ ] None

[ ] Stopped in__________

[ ] Yes, I do

Amount per day__________

Drug use

[ ] Never

[ ] Only in the past

Any history of IV Drug Use [ ] Yes [ ] No

[ ] Yes, I do

Any IV Drug Use [ ] Yes [ ] No

Types of drugs used______________________________

Do you exercise?

[ ] No

[ ] Yes If so, type____________________ How often__________

REVIEW OF SYSTEMS

Are you **CURRENTLY** having any of the following? If yes, indicate when occurred and symptoms.

	Symptoms	When did they start?
[ ] Bowel Problems	__________	__________
[ ] Bladder Problems	__________	__________
[ ] Prostate Problems	__________	__________
[ ] Erectile Problems	__________	__________
[ ] Gynecologic Problems	__________	__________
[ ] Weight Loss	__________	__________

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REVIEW OF SYSTEMS CONTINUED

	Symptoms	When did they start?
[ ] Weight Gain		
[ ] Fever		
[ ] Sweats		
[ ] Chills		
[ ] Nasal Congestion		
[ ] Cough		
[ ] Runny Nose		
[ ] Hearing Loss		
[ ] Vision Change		
[ ] Chest Pain/Palpitations		
[ ] Shortness of Breath		
[ ] Lightheadedness		
[ ] Dizziness		
[ ] Diabetes		
[ ] Thyroid Problems		
[ ] Rash		
[ ] Skin Discoloration		
[ ] Sleep Problems		
[ ] Depression		
[ ] Stress		
[ ] Difficulty with Balance or Coordination		
[ ] Walk with Limp or Drop Foot		
[ ] Seizures		
[ ] Paralysis in any Extremity		
[ ] Numbness in any Extremity		
[ ] Weakness in any Extremity		
[ ] Headaches		
[ ] Abdominal Pain		
[ ] Abdominal Swelling		
[ ] Abdominal Bloating		
[ ] Vomiting		
[ ] Reflux		
[ ] Heartburn		
[ ] Constipation		
[ ] Diarrhea		
[ ] Bloody Stools		
[ ] Joint Pain		
[ ] Joint Swelling		
[ ] Easy Bruising		
[ ] Fatigue/Lethargy		

PATIENT SIGNATURE: ______________________ **DATE OF BIRTH** ____________

Reviewed by: ______________________ Date: ____________

11/2016