

Spine Past Medical History

Patient Name: _____

Date: _____

PMH: Any new medical problems? Y / N _____

Any new medications? Y / N _____

Primary Medical Physician: _____

Office Address _____

Phone Number: _____

- Medical problems:
- | | |
|---|---|
| <input type="checkbox"/> Cardiac/Hypertension | <input type="checkbox"/> Neurologic, stroke |
| <input type="checkbox"/> Pulmonary | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Vascular | <input type="checkbox"/> Bleeding |
| <input type="checkbox"/> Infectious Diseases | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Anesthetic Problems | <input type="checkbox"/> Other? _____ |

Surgical History: _____

Family Medical History:

- | | |
|---|---|
| <input type="checkbox"/> Cardiac/Hypertension | <input type="checkbox"/> Neurologic, stroke |
| <input type="checkbox"/> Pulmonary | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Infectious Diseases | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Anesthetic Problems | <input type="checkbox"/> Other? _____ |

Social History: Smoking? Y / N _____ packs per day Quit when? _____

Drinking? Y / N _____

Occupation _____

Medications: _____

Allergies: _____

Review of Systems:

- | | | |
|--|--|--|
| <input type="checkbox"/> Fever, weight loss, fatigue | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Depression, Anxiety |
| <input type="checkbox"/> Skin problems, rashes | <input type="checkbox"/> Constipation or diarrhea | <input type="checkbox"/> Diabetes, Thyroid |
| <input type="checkbox"/> Neurologic problems, stroke | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Bleeding problems |
| <input type="checkbox"/> Ear, nose or throat issues | <input type="checkbox"/> Difficulty with urinating | <input type="checkbox"/> Menstrual problems |
| <input type="checkbox"/> Temporo-mandibular pain | <input type="checkbox"/> Vascular Insufficiency | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Visual changes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Headaches, migraines | <input type="checkbox"/> Infectious diseases | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Asthma, shortness of breath | <input type="checkbox"/> HIV | <input type="checkbox"/> DVT |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Other _____ |