HEALTH HISTORY

Date: _____

erlanger Neurosurgery and Spine

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All information is treated as strictly confidential. The more fully you complete this form, the better we will be able to diagnose and treat you.

Name: _____ **DOB:** _____ **Age:** _____

Office Use Only: Temp_____ HR_____ BP_____ RR_____ HT_____ WT_____ BMI_____

CHIEF COMPLAINT (Why are you seeing doctor today?)

_____

_____

Location of Pain: □ Head □ Neck □ Back □ Other _____ Date Started: _____

Does the Pain extend into your □ **ARMS** or □ **LEGS**? □ Yes □ No

How bad is your pain on a scale of 1-10 (1 = minimal & 10 = worst) At its Best: _____ At its Worst: _____

What makes it - Better_____ Worse_____

Have you been treated with: □ Physical Therapy □ Chiropractor □ Pain Management □ NSAIDS (Advil/Aleve)

CURRENT AND PAST MEDICAL PROBLEMS

□ Hypertension □ Diabetes □ Osteoporosis _____

_____ _____

_____ _____

_____ _____

SURGERIES	YEAR	ANY COMPLICATIONS

MEDICAL ALLERGIES

_____

_____

ALLERGY SYMPTOMS

_____

_____

CURRENT MEDICATIONS (RX or OTC)

_____

_____

_____

_____

_____

Blood Thinner's? _____

STRENGTH / DOSAGE (attach list for numerous meds)

_____

_____

_____

_____

_____

_____

SOCIAL HISTORY

Occupation: _____

Marital Status: □ Single □ Married □ Divorced □ Widow

Children: □ Yes □ No How Many? _____

Do you Smoke? □ Yes □ No □ Quit _____ how long □ Never Smoked

□ Cigarettes _____ packs per day for _____ year's □ Cigars/Pipe □ Smokeless Tobacco

Do you drink Alcohol? □ Never □ Rarely □ Socially □ Regularly

FAMILY HISTORY	Alive	Age	Medical Problems	Deceased	Cause of Death
Father	□	____	_____	□	_____
Mother	□	____	_____	□	_____
Sister/Brother	□	____	_____	□	_____

Sister/Brother □ ____ _____ □ _____

MEDICAL REVIEW

* Check all that apply *

	Current Problem	Past Problem
Allergy / Immunological		
Asthma	□	□
Hives	□	□
Immune Deficiency	□	□
Swelling	□	□
Constitutional / General Body		
Excessive Fatigue	□	□
Fever	□	□
Weight Gain	□	□
Weight Loss	□	□
Ear, Nose, Throat, & Mouth		
Balance Problems	□	□
Ear Pain	□	□
Hearing Loss	□	□
Inability to Smell	□	□
Nosebleeds	□	□
Ringing of Ears	□	□
Eyes		
Cataracts	□	□
Glaucoma	□	□
Injuries	□	□
Vision Loss	□	□
Endocrine		
Diabetes Type I	□	□
Diabetes Type II	□	□
Excessive Thirst	□	□
Excessive Urination	□	□
Hormone Problems	□	□
Thyroid Problems	□	□
Gastrointestinal		
Abdominal Pain	□	□
Blood in Stool	□	□
Blood in Vomit	□	□
Colon Cancer	□	□
Constipation	□	□
Jaundice	□	□
Liver Disease	□	□
Nausea	□	□
Vomiting	□	□
Ulcers	□	□
Hematology / Blood Disorder		
Anemia	□	□
Free Bleeder	□	□
Genitourinary		
Bladder Infections	□	□
Blood in Urine	□	□
Incontinence	□	□
Kidney Stones	□	□
Trouble Starting/Stopping Stream of Urine	□	□
Prostate Cancer	□	□
UTI	□	□
Uterine/Cervical Cancer	□	□

	Current Problem	Past Problem
Heart		
Last EKG _____	□	□
Chest Pain	□	□
High Blood Pressure	□	□
Leg Pain when walking	□	□
Musculoskeletal		
Muscle Ache	□	□
Weakness	□	□
Fatigue	□	□
Spasms	□	□
Neurological		
Blackout spells	□	□
Seizures	□	□
Coordination Trouble	□	□
Double/Blurred Vision	□	□
Facial Weakness	□	□
Speech Difficulty	□	□
Psychiatric		
Bipolar	□	□
Depression	□	□
Psychiatric Treatment	□	□
Respiratory		
Last Chest X-ray _____		
Oxygen Use	□	□
CPAP Use	□	□
Asthma	□	□
Bronchitis	□	□
COPD	□	□
Emphysema	□	□
Lung Cancer	□	□
Pleurisy	□	□
Pneumonia	□	□
Shortness of Breath	□	□
Skin / Integumentary		
Last Mammogram _____		
Breast Disorder	□	□
Easy Bruising	□	□
Skin Cancer	□	□
Skin Ulcers	□	□
Sores or Abscesses	□	□
Thin Skin	□	□

Any Other Types Cancer

_____

Any Types of Stents

_____

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

PATIENT SIGNATURE: _____ DATE: _____

revised 1.8.21