SPINE INSTITUTE OF IDAHO

Patient History Form

Date of Visit: / /

Name: **Age:**

Height: feet inches **Weight:** Pounds

MEDICAL ILLNESSES:

- ❑ Tuberculosis
- ❑ Mental Illness
- ❑ Gout
- ❑ Hypertension
- ❑ Heart Attack
- ❑ Peptic Ulcer Disease
- ❑ None
- ❑ Kidney Disease
- ❑ Epilepsy
- ❑ Allergy
- ❑ Cancer
- ❑ Asthma
- ❑ COPD
- ❑ Other_____ _____
- ❑ Spinal Disorder
- ❑ Diabetes
- ❑ Arthritis
- ❑ Migraines
- ❑ Thyroid

SURGERIES:

- ❑ Tonsillectomy
- ❑ Broken Bone Surgery
- ❑ Hysterectomy
- ❑ Cataract Surgery
- ❑ Other_____ _____ _____
- ❑ Appendectomy
- ❑ Hemorrhoidectomy
- ❑ Bowel Surgery
- ❑ Gall Bladder Surgery
- ❑ Cardiac Surgery
- ❑ Cardiac Stent Placement

FAMILY HISTORY:

- ❑ Tuberculosis
- ❑ Mental Illness
- ❑ Gout
- ❑ Hypertension
- ❑ Heart Attack
- ❑ None
- ❑ Other_____ _____ _____
- ❑ Kidney Disease
- ❑ Epilepsy
- ❑ Allergy
- ❑ Cancer
- ❑ Blood Clots
- ❑ Spinal Disorder
- ❑ Diabetes
- ❑ Arthritis
- ❑ Migraines
- ❑ Problems with Anesthesia

PERSONAL HISTORY:

❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed
❑ Student ❑ Unemployed ❑ Homemaker ❑ Retired ❑ Job_____

Number of Children_____ Number of Children at Home_____

Are you Pregnant? ❑ Yes ❑ No

What Medications do you take? (Please list each medication and dosage.)

-
-
-
-
-
-

Are you allergic to any medications, or do any medications make you sick? (Please List)

-
-
-
-

SOCIAL HISTORY: **(Circle One)**

Alcohol Intake:	**Never**	**Rarely**	**Moderately**	**Daily**
Tobacco:	**Never Smoked**	**Cigarettes Pack per Day_____**	**Quit Date / /**	**Chew**

System Review: **Do you or have you ever had any of these? Check all those that apply**

- ❑ **Fevers**
- ❑ **Chills**
- ❑ **Weight Loss**
- ❑ **Night Sweats**
- ❑ **Night Pain**
- ❑ **Stiff Neck**
- ❑ **Nose Bleed**
- ❑ **Asthma or Wheezing**
- ❑ **Pneumonia or Bronchitis**
- ❑ **Chest Pain or Angina**
- ❑ **Heart Attack**
- ❑ **Hormone Therapy**
- ❑ **Liver Disease**
- ❑ **Gall Bladder Disease**
- ❑ **Pain with Walking Relieved by Rest**
- ❑ **Paralysis**
- ❑ **Convulsions or Seizures**
- ❑ **Skin Ulcerations or Breakdown**
- ❑ **Abnormal Bleeding**
- ❑ **Immune Deficiency**
- ❑ **Headaches**
- ❑ **Jaundice**
- ❑ **Glaucoma**
- ❑ **Loss of Vision**
- ❑ **Sinus Infection or Disorder**
- ❑ **Shortness of Breath**
- ❑ **Difficulty Breathing**
- ❑ **Heart Murmur or Arrhythmia**
- ❑ **Heart Failure**
- ❑ **Hepatitis**
- ❑ **Kidney Disease**
- ❑ **Difficulty in Walking**
- ❑ **Weakness of Muscles or Joints**
- ❑ **Psychiatric Problems or Care**
- ❑ **Wound Healing Problems**
- ❑ **Blood Clots**
- ❑ **Anemia or Blood Deficiency**
- ❑ **Cancer List Type:**

Who filled out this form?

- ❑ **Patient**
- ❑ **Other (Describe Relation)**

Patient Signature:

Both sides of form reviewed by physician: _____ Physician Initials