

SOUTH SHORE NEUROSPINE GROUP, LLC

Patient Medical History - Please Complete This Form Accurately As It Will Become A Part Of Your Medical Record

Name _____ Age _____ Today's Date _____

Your job description _____

Are you currently working (circle)? YES NO Stopped working on: _____

Have you ever had heart surgery (circle)? YES Date: _____ NO

Are you taking a blood thinner (circle)? YES Name of drug: _____ NO

Have you ever had spinal or brain surgery (circle)? YES NO

If yes please list date(s), type(s) of surgery, and surgeon's name.

Have you ever had anesthesia (circle)? YES NO Anesthesia complications? YES NO

Allergies (Medications or Dyes): _____

Medications (With Doses): _____

Pharmacy Name and Phone: _____

Are you being treated for any of the following? Check all that apply.

- | | | |
|--|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Recreational Drug Use |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer - Type _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Hepatitis - Type _____ |
| <input type="checkbox"/> Brain Tumor | <input type="checkbox"/> Aneurysm of Brain or Abdomen | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Other _____ | <input type="checkbox"/> CPAP |

Please estimate your: Height _____ Weight _____

Have you recently experienced any of the following?:

- | | | |
|-------------------------------------|---|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Bowel/Bladder Problems | <input type="checkbox"/> Weight Loss |

Do you smoke cigarettes? _____ Did you ever? _____ When did you quit? _____

Do you drink alcohol, beer or wine (circle)? YES NO Daily Weekly Occasionally

Does anyone in your immediate family have any of the following problems? Please identify family member relationship.

- | | |
|--------------|----------------------|
| Cancer _____ | Diabetes _____ |
| Stroke _____ | Heart Disease _____ |
| | Spine Problems _____ |

Patient Signature: _____