

**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: \_\_\_\_\_ Date \_\_\_\_\_ MD/PA: \_\_\_\_\_ Date: \_\_\_\_\_

