Date: _____

Health History

Patient Name: _____ Date of Birth: _____

Allergies to Medications/Other: YES NO

If yes, please list allergies: _____

Taking Blood Thinning Medication? YES NO IF Yes, Name of Medication: _____

Medications	Dosage	How Taken and Reason

Past Medical History: **Check if you have had any of the following:**

- ☐ Arthritis, Osteo
- ☐ Cerebrovascular Disease
- ☐ COPD
- ☐ Emphysema
- ☐ Hypertension
- ☐ Neuropathy
- ☐ Sleep Apnea
- ☐ Atrial Fibrillation
- ☐ CHF
- ☐ Coronary Artery Disease
- ☐ Fibromyalgia
- ☐ Irritable bowel syndrome
- ☐ Peripheral Vascular Disease
- ☐ Substance Abuse
- ☐ Bipolar Disorder
- ☐ Chronic Back Pain
- ☐ Depression
- ☐ Gastrointestinal Problems
- ☐ Liver Disease
- ☐ Restless Leg Syndrome
- ☐ Urinary Incontinence
- ☐ Cancer
- ☐ Chronic Kidney Disease
- ☐ Diabetes Mellitus Type II
- ☐ Headaches
- ☐ Long Term Anticoagulant Use
- ☐ Seizures

Previous Hospitalization/Surgeries **Check if you have had any of the following:**

- ☐ Brain Surgery
- ☐ Spine Surgery
- ☐ Cardiac Pacemaker Placement
- ☐ Whooping Cough
- ☐ CABG
- ☐ Carpal Tunnel Release Surgery
- ☐ Cardiac Defibrillator Placement
- ☐ Migraine Headaches
- ☐ Colon Surgery
- ☐ Knee Surgery
- ☐ Permanent Pain Pump
- ☐ Hemorrhoids
- ☐ Joint Replacement Surgery
- ☐ Shoulder Surgery
- ☐ Spinal Cord Stimulator
- ☐ Thyroid Disease

Family History **Check if any of the following apply and circle which parent:**

- ☐ Arthritis Mother Father
- ☐ Heart Disease Mother Father
- ☐ Coronary Artery Disease Mother Father
- ☐ Cancer Mother Father
- ☐ High Blood Pressure Mother Father
- ☐ Diabetes Mother Father
- ☐ Stroke Mother Father

Patient Social History: (Circle appropriate response)

Use of Alcohol: YES NO Drinks per week _____ Wine Beer Liquor

Use of drugs: YES NO Times per week_____ Marijuana Meth/Amphetamines Cocaine IV

Use of tobacco: Never Previously, quit: _____ Current Packs/day: _____ # of Years Smoking _____
Smokeless Tobacco Use Yes No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I consent to having treatment with the physicians at NeuroSpinecare, Inc.

_____ _____
Signature of patient, parent, or guardian Date