Patient Name:	Health History	Date:	
Allergies to Medications/Other: YFS NO  If yes, please list allergies:  Taking Blood Thinning Medication?  YES NO  If Yes, Name of Medication:  Wedications  Dosage	neatti fiistory		
If yes, please list allergies:  Taking Blood Thinning Medication?  YES NO  IF Yes, Name of Medication:  Dosage  How Taken and Reason  Past Medical History:  Check if you have had any of the following:  Cerebrovascular Disease CCPP  Coronary Artery Disease Epbressyndigs Hypertension Hypertension Surgery Sile April Eprillation Control	Patient Name:	Date of Birth:	
If yes, please list allergies:  Taking Blood Thinning Medication?  YES NO  IF Yes, Name of Medication:  Dosage  How Taken and Reason  Past Medical History:  Check if you have had any of the following:  Cerebrovascular Disease CCPP  Coronary Artery Disease Epbressyndigs Hypertension Hypertension Surgery Sile April Eprillation Control	Allergies to Medications/Other YES	NO.	
Taking Blood Thinning Medication?  VES NO IF Yes, Name of Medication:    Dosage		No	
Past Medical History: Check if you have had any of the following:    Arthritis, Osteo   Cerebrovascular Disease   CHF   Coronary Artery Disease   COPD   Coronary Artery Disease   COPD   Coronary Artery Disease   CHF   Coronary Artery Disease   Coppensation   Diabetes Mediture Type II   Headaches   Liver Disease   Coppensation   Peripheral Vascular Disease   Seizures   Liver Disease   Coronary Artery Disease   Coronary Artery Disease   Coronary Artery Disease   Coronary Artery Disease   Diabetes Mediture Type II   Headaches   Liver Disease   Coronary Artery Disease   Mother Father   Coronary Artery Disease   Mother Father   High Blood Pressure   Mother Father   Stroke   Mother Father   Coronary Artery Disease   Mother Father   High Blood Pressure   Mother Father   Granery	•	VEC. NO	
Past Medical History: Check if you have had any of the following:    Arthritis, Osteo	Taking Blood Ininning Medication: YES NO IF Yes, Name of Medication:		
Arthritis, Osteo Cerebrovascular Disease COPD Coronary Artery Disease COPD Emphysema Hypertension Neuropathy Sleep Apnea  Charger Feripheral Vascular Disease Substance Abuse  Check if you have had any of the following:  Cardiac Defibrillator Placement Whooping Cough  Arthritis Mother Father Heart Disease Mother Father Heart Disease Mother Father High Blood Pressure High Blood Pressure Mother Father  Cardiac Defibrillator Placement High Blood Pressure Mother Father Use of Alcohol: YES NO Drinks per week Use of Itobacco: Never Previously, quit: Chronic Back Pain Chronic Back Mellius Type II Headaches Colon Surgery Shoulder Surg	Medications	Dosage How Taken and Reason	
Arthritis, Osteo Cerebrovascular Disease COPD Coronary Artery Disease COPD Emphysema Hypertension Neuropathy Sleep Apnea  Charger Feripheral Vascular Disease Substance Abuse  Check if you have had any of the following:  Cardiac Defibrillator Placement Whooping Cough  Arthritis Mother Father Heart Disease Mother Father Heart Disease Mother Father High Blood Pressure High Blood Pressure Mother Father  Cardiac Defibrillator Placement High Blood Pressure Mother Father Use of Alcohol: YES NO Drinks per week Use of Itobacco: Never Previously, quit: Chronic Back Pain Chronic Back Mellius Type II Headaches Colon Surgery Shoulder Surg			
Arthritis, Osteo Cerebrovascular Disease COPD Coronary Artery Disease COPD Emphysema Hypertension Neuropathy Sleep Apnea  Charger Feripheral Vascular Disease Substance Abuse  Check if you have had any of the following:  Cardiac Defibrillator Placement Whooping Cough  Arthritis Mother Father Heart Disease Mother Father Heart Disease Mother Father High Blood Pressure High Blood Pressure Mother Father  Cardiac Defibrillator Placement High Blood Pressure Mother Father Use of Alcohol: YES NO Drinks per week Use of Itobacco: Never Previously, quit: Chronic Back Pain Chronic Back Mellius Type II Headaches Colon Surgery Shoulder Surg			
Arthritis, Osteo Cerebrovascular Disease COPD Coronary Artery Disease COPD Emphysema Hypertension Neuropathy Sleep Apnea  Charger Feripheral Vascular Disease Substance Abuse  Check if you have had any of the following:  Cardiac Defibrillator Placement Whooping Cough  Arthritis Mother Father Heart Disease Mother Father Heart Disease Mother Father High Blood Pressure High Blood Pressure Mother Father  Cardiac Defibrillator Placement High Blood Pressure Mother Father Use of Alcohol: YES NO Drinks per week Use of Itobacco: Never Previously, quit: Chronic Back Pain Chronic Back Mellius Type II Headaches Colon Surgery Shoulder Surg			
Arthritis, Osteo Cerebrovascular Disease COPD Coronary Artery Disease COPD Emphysema Hypertension Neuropathy Sleep Apnea  Check if you have had any of the following:  Cardiac Pacement Whooping Cough  Arthritis Mother Father Heard Disease Mother Father Heard Disease Mother Father High Blood Pressure High Blood Pressure Mother Father High Blood Pressure Mother Father  Coronary Artery Disease Restless Leg Syndrome Urinary Incontinence  Colon Surgery Spine Surgery Cardiac Pacemaker Placement Whooping Cough  Arthritis Mother Father High Blood Pressure High Blood Pressure Mother Father  Cancer Mother Father High Blood Pressure Mother Father  Whoe Beer Liquor Use of Alcohol: VES NO Drinks per week Marijuana Meth/Amphetamines Cocaine IV Use of drugs: VES NO Times per week Current Packs/day:  Brain Surgery Check if to Check in Chronic Back Pain Chro			
Arthritis, Osteo Cerebrovascular Disease COPD Coronary Artery Disease COPD Emphysema Hypertension Neuropathy Sleep Apnea  Check if you have had any of the following:  Cardiac Pacement Whooping Cough  Arthritis Mother Father Heard Disease Mother Father Heard Disease Mother Father High Blood Pressure High Blood Pressure Mother Father High Blood Pressure Mother Father  Coronary Artery Disease Restless Leg Syndrome Urinary Incontinence  Colon Surgery Spine Surgery Cardiac Pacemaker Placement Whooping Cough  Arthritis Mother Father High Blood Pressure High Blood Pressure Mother Father  Cancer Mother Father High Blood Pressure Mother Father  Whoe Beer Liquor Use of Alcohol: VES NO Drinks per week Marijuana Meth/Amphetamines Cocaine IV Use of drugs: VES NO Times per week Current Packs/day:  Brain Surgery Check if to Check in Chronic Back Pain Chro	_		
Arthritis, Osteo Cerebrovascular Disease COPD Coronary Artery Disease COPD Emphysema Hypertension Neuropathy Sleep Apnea  Charger Feripheral Vascular Disease Substance Abuse  Check if you have had any of the following:  Cardiac Defibrillator Placement Whooping Cough  Arthritis Mother Father Heart Disease Mother Father Heart Disease Mother Father High Blood Pressure High Blood Pressure Mother Father  Cardiac Defibrillator Placement High Blood Pressure Mother Father Use of Alcohol: YES NO Drinks per week Use of Itobacco: Never Previously, quit: Chronic Back Pain Chronic Back Mellius Type II Headaches Colon Surgery Shoulder Surg	Past Medical History: Check if you have had any of the following:		
Brain Surgery Spine Surgery Spine Surgery Cardiac Pacement Whooping Cough  Check if any of the following apply and circle which parent:  Arthritis Heart Disease Coronary Artery Disease Mother Father Coronary Artery Disease Mother Father  Use of Alcohol: YES NO Drinks per week Use of tobacco: Never  Cardiac Defibrillator Placement Whooping Cough  Colon Surgery Knee Surgery Knee Surgery Spinal Cord Stimulator Permanent Pain Pump Hemorrhoids  Thyroid Disease  Mother Father Diabetes Mother Father Stroke Mother Father Stroke Mother Father Wine Beer Liquor Warijuana Meth/Amphetamines Cocaine IV Use of tobacco: Never Previously, quit:  Current Packs/day: # of Years Smoking  Use of Years Smoking  Colon Surgery Knee Surgery Knee Surgery Knee Surgery Knee Surgery Knee Surgery Knee Surgery Noholder Surgery Spinal Cord Stimulator Thyroid Disease Nother Father Spoulation Spinal Cord Stimulator Thyroid Disease Nother Father Spinal Cord Stimulator Thyroid Disease Nother Father Diabetes Mother Father Stroke Mother Father Mother Father Stroke Mother Father Wine Beer Liquor Use of forugs: YES NO Times per week Marijuana Meth/Amphetamines Cocaine IV Use of tobacco: Never Previously, quit: Current Packs/day: # of Years Smoking	Arthritis, Osteo Cerebrovascular Disease COPD Coronar Emphysema Hypertension Neuropathy  Atrial Fi CHF Coronar Fibromy Irritable Peripher	brillation Bipolar Disorder Cancer Chronic Back Pain Chronic Kidney Disease y Artery Disease Depression Diabetes Mellitus Type II ralgia Gastrointestinal Problems Headaches bowel syndrome Liver Disease Long Term Anticoagulant Use ral Vascular Disease Restless Leg Syndrome Seizures	
Spine Surgery Cardiac Pacemaker Placement Whooping Cough Check if any of the following apply and circle which parent:  Arthritis Heart Disease Coronary Artery Disease Mother Father Coronary Artery Disease Mother Father Coronary Artery Disease Mother Father Use of Alcohol:  YES NO Drinks per week Use of drugs: YES NO Times per week Use of tobacco: Never  Note of Alcohol:  Never  Carcar Mother Father Hemorrhoids Nother Father Permanent Pain Pump Hemorrhoids Thyroid Disease Nother Father Diabetes Mother Father Stroke Mother Father Stroke Mother Father Wine Beer Liquor Marijuana Meth/Amphetamines Cocaine IV Use of tobacco: Never Previously, quit:  Carcar Mother Father Mother Father Wine Beer Liquor Wine Marijuana Meth/Amphetamines Cocaine IV Current Packs/day:  # of Years Smoking  # of Years Smoking	Previous Hospitalization/Surgeries Check if you have had any of the following:		
Arthritis	Spine Surgery Carpal 7 Cardiac Pacemaker Placement Cardiac	Funnel Release Surgery     Knee Surgery     Shoulder Surgery       Defibrillator Placement     Permanent Pain Pump     Spinal Cord Stimulator	
Heart Disease Mother Father Mother Father Coronary Artery Disease Mother Father Mother Father Mother Father Stroke Mother Father Mother Father Stroke Mother Father Mother Father Mother Father Mother Father Mother Father Stroke Mother Father	Family History Check if any of the following apply and circle which parent:		
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	Heart Disease Mother Father		
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	Patient Social History: (Circle appropriate response)		
Use of tobacco: Never Previously, quit: Current Packs/day: # of Years Smoking	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		
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			