ADVANCED SPINE CENTER

ESTABLISHED PATIENT UPDATED HEALTH HISTORY

Patient Name:		DOB: / /

CHIEF COMPLAINT: ☐ Neck ☐ Upper Back ☐ Shoulder ☐ Arm ☐ Hand ☐ Mid Back ☐ Low Back ☐ Hip ☐ Buttocks ☐ Lower Leg ☐ Tail Bone ☐ SI Joint ☐ Other: _____

VITALS: Height: ___ft. _____in. Weight: _____lbs.

MEDICATION HISTORY: ***Medication*** Allergies: Do you have any allergies? ☐ Yes ☐ No ☐ NKDA

Please list all **medication allergies**, include seasonal and food allergies:

_____

Current Medications: Please list any new or discontinued medications you take on a regular basis:

_____

FAMILY HISTORY	Have any direct relatives had any of the following disorders?
Father	☐ None ☐ Diabetes ☐ Heart Disease ☐ Hypertension ☐ Bleeding Problem ☐ Epilepsy ☐ Stroke ☐ Connective Tissue ☐ Muscular Dystrophy ☐ Osteoporosis ☐ Rheumatoid Arthritis ☐ Cancer :_____
Mother	☐ None ☐ Diabetes ☐ Heart Disease ☐ Hypertension ☐ Bleeding Problem ☐ Epilepsy ☐ Stroke ☐ Connective Tissue ☐ Muscular Dystrophy ☐ Osteoporosis ☐ Rheumatoid Arthritis ☐ Cancer :_____
☐**Sister** ☐**Brother**	☐ None ☐ Diabetes ☐ Heart Disease ☐ Hypertension ☐ Bleeding Problem ☐ Epilepsy ☐ Stroke ☐ Connective Tissue ☐ Muscular Dystrophy ☐ Osteoporosis ☐ Rheumatoid Arthritis ☐ Cancer :_____

SOCIAL HISTORY	
Do you use tobacco?	☐ Current Everyday Smoker ☐ Former Smoker ☐ Never a Smoker ☐ Dip/Chew ☐ Vap/E-Cg
Do you drink alcohol?	☐ None ☐ Occasional ☐ Moderate ☐ Heavy
Psycho/Social	☐ None ☐ Insomnia ☐ Depression ☐ Illicit Drug Use ☐ Anxiety ☐ Drug/Alcohol Addiction

SURGICAL HISTORY Select all previous hospitalizations/surgeries:			
☐ Arthroscopy: Knee	☐ Right ☐ Left	☐ Total Knee Replacement	☐ Right ☐ Left
☐ Arthroscopy: Shoulder	☐ Right ☐ Left	☐ Total Shoulder Replacement	☐ Right ☐ Left
☐ Carpal Tunnel Release	☐ Right ☐ Left	☐ Spinal Surgery: Indicate Level:	
☐ Rotator Cuff Repair	☐ Right ☐ Left	☐ Neck:	☐ Back:
☐ Total Hip Replacement	☐ Right ☐ Left	☐ Appendectomy	☐ Hernia Repair
☐ Aneurysm (Brain) Surgery	☐ Aortic Bypass/Vascular Surgery		☐ LAP Band/Gastric
☐ Hysterectomy	☐ Heart Surgery		☐ Stents
☐ Mastectomy	☐ Malignancy/Cancer (type):		☐ Cesarean Surgery
☐ Cholecystectomy (Gallbladder)	☐ Plastic Surgery		☐ Cataract (Eye) Surgery
☐ Other Surgery:			☐ None

PAST MEDICAL HISTORY : Personal history of any of the following? If so, please check below. If no, please state none.			
☐ Aneurysm: Where:	☐ Emphysema	☐ Kidney Disease	
☐ Angina (Chest Pain)	☐ Epilepsy	☐ Kidney Stones	
☐ Arthritis: Type:	☐ Heart Attack	☐ MRSA Infection	
☐ Asthma	☐ Hepatitis: Type:	☐ Pacemaker	
☐ Bone or Joint Infections	☐ HIV/AIDS	☐ Phlebitis (Blood Clots)	
☐ Cancer: Type:	☐ High Cholesterol	☐ Pulmonary Embolism	
☐ Chemo/Radiation	☐ Hypertension	☐ Reaction to Anesthesia	
☐ COPD	☐ Hyperthyroidism	☐ Seizures	
☐ Congestive Heart Failure	☐ Hypothyroidism	☐ Stomach Ulcers	
☐ Diabetes: Type:	☐ Last A1C:	☐ Stroke-TIA	
		☐ Tuberculosis	
☐ Other	☐ None	Patient Sig:	Date:

REVIEW OF SYSTEMS Please indicate if you have experienced any of the following symptoms in the last 6 months				
CONSTITUTIONAL:				☐ **NONE**
☐ Significant weight gain	☐ Significant weight loss	☐ Night Sweats		
☐ Weight gain: ____lbs.	☐ Weight loss: ____lbs.	☐ Exercise Intolerance		
EYES:				☐ **NONE**
☐ Double Vision	☐ Vision Change	☐ Vision Loss	☐ Blurred Vision	☐ Wears glasses and contact lenses
ENMT (Ears, Nose, Mouth/Throat):				☐ **NONE**
☐ Difficulty Hearing	☐ Hearing Loss	☐ Hoarseness	☐ Trouble Swallowing	☐ Sore Throat ☐ Snoring
CARDIOVASCULAR:				☐ **NONE**
☐ Palpitations	☐ Chest Pain on Exertion	☐ Heart Murmur	☐ No Treating Cardiologist	
☐ Cardiologist: _____ Phone #: _____				
RESPIRATORY:				☐ **NONE**
☐ C-Pap	☐ Chronic Cough	☐ Pneumonia	☐ Sleep Apnea	☐ Shortness of Breath
GASTROINTESTINAL:				☐ **NONE**
☐ Nausea	☐ Heartburn	☐ Vomiting	☐ Loss of Appetite	☐ Constipation ☐ Blood in Stool
GENITOURINARY:				☐ **NONE**
☐ Kidney Problems	☐ Painful Urination	☐ Incontinence	☐ Blood in Urine	
☐ Bowel/Bladder Changes: _____				
MUSCULOSKELETAL:				☐ **NONE**
☐ Osteoporosis	☐ Muscle Weakness	☐ Fractures	☐ Difficulty Walking	
SKIN:				☐ **NONE**
☐ Lumps	☐ Lacerations	☐ Frequent Rashes	☐ Psoriasis	☐ Skin Ulcers ☐ Jaundice
NEUROLOGIC:				☐ **NONE**
☐ Loss of Coordination	☐ Frequent Falls	☐ Dizziness	☐ Numbness	☐ Headaches ☐ Migraines
PSYCHIATRIC:				☐ **NONE**
☐ Sleep Disorder	☐ Depression	☐ Illicit Drug Use	☐ Anxiety	☐ Drug/Alcohol Addiction
ENDOCRINE:				☐ **NONE**
☐ Heat/Cold Intolerance	☐ Fever	☐ Fatigue		
HEMATOLOGIC:				☐ **NONE**
☐ Anemia	☐ Easy Bleeding	☐ Phlebitis (Clots)	☐ Easy Bruising	