Parkway Brain and Spine

Patient Health History

Name: _____

Date of Birth: _____

Please list any and all allergies along with reactions:

_____

_____

Please tell us in your own words why you are being seen today:

_____

Please list all medications to include over the counter medications:

□ **No Current Medications**

Medication Name	Dose (MG, MCG)	Frequency
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
Please list any additional medications on a sheet of paper		

When did you receive your last Influenza Vaccine? 20_____, Did not receive _____

When did you receive your last Pneumonia Vaccine? 20_____, Did not receive _____

Family History:

Family Member	Alive/Deceased	Medical Problem(s)
Mother	A / D	
Father	A / D	
Sister/Brother	A / D	
Sister/Brother	A / D	
Sister/Brother	A / D	
Sister/Brother	A / D	
Sister/Brother	A / D	

Social History:

Tobacco Use:

Do you smoke: Yes / No

How Many Packs Per Day _____

For How Many Years _____

History of Substance Abuse: Yes/ No

If yes, How Often _____, For How Long_____

Alcohol Use:

I use Alcohol : Never/ 1-2 Times per Year/ 1-2 Times Per Month/ 1-2 Times Per Week

Name: _____
Date of Birth: _____

Health History Continued

Living Situation:
Do you Live alone? Yes /No
If you have surgery is there someone to help you at home? Yes/ No
I live in a: House Apartment
Number of Stories: _____

Exercise History:
I exercise: Never/ Daily/ Weekly/ Monthly
The type of exercise is: Aerobics/ Walking/ Running/ Weight Lifting

Past Surgical History:
□ No Past Surgeries

Surgery	Year	Facility Surgery Completed
Please list any additional surgeries on a sheet of paper		

Have you ever had a Surgical Complication? Yes/ No
If yes, Please list the surgery and the complication that was noted:

_____

_____

Do have a need to take Antibiotics prior to any procedures ? Yes / No

Past Medical Problems: Please Circle All that Apply:

Y/N Use of Blood Thinners	Y/N Infectious Diseases(MRSA,TB)	Y/N Coronary Artery Disease
Y/N Anxiety/ Depression	Y/N Osteoarthritis	Y/N Stroke
Y/N Arthritis	Y/N Osteoporosis	Y/N Diabetes
Y/N Asthma	Y/N Rheumatoid Arthritis	Y/N Fibromyalgia
Y/N Bipolar Disorder	Y/N Seizure Disorder	Y/N Glaucoma
Y/N Cancer	Y/N Sleep Apnea	Y/N High Blood Pressure
Y/N Congestive Heart Failure	Y/N Thyroid Disease	Y/N Heart Attack
Y/N COPD	Y/N Vertebral Artery Stenosis	Y/N High Cholesterol
Y/N Head Injury	Y/N HIV	

Have you ever been diagnosed with Cancer? Yes/ No
If yes, What Type _____, When were you diagnosed? _____
Do you see a Cardiologist? Yes/No
If yes, Name of Cardiologist _____ , When were you Last Seen? _____