Name: _____

Date of Birth: _____

Date of Visit: _____

SPINE COLORADO

Health History Form

List all past medical problems:

List all current medical problems:

Past Surgical History

Have you ever had any problems with anesthesia? ☐ Yes ☐ No Explain: _____

Surgery	Year	Complications

Are you currently pregnant or do you think you are pregnant? ☐ Yes ☐ No

Do you have Stents, Shunts, Pacemaker, Blood filters or any other metal in your body? ☐ Yes ☐ No

List all current medications:(including over-the-counter and herbal/supplements)	

What medications have you tried in the past: _____

List all DRUG ALLERGIES including adverse reactions: _____

Review of Systems

Are you currently having or have you had problems with your:

	Check		Describe all yes responses
Fever or Chills	☐ Yes	☐ No	
Eyes	☐ Yes	☐ No	
Ears, Nose, Throat	☐ Yes	☐ No	
Lungs, Breathing	☐ Yes	☐ No	
Digestion/Ulcers	☐ Yes	☐ No	
Bowel movement	☐ Yes	☐ No	
Bladder problems	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Heart problems/Chest Pain (including rheumatic fever, Pacemaker or Defibrilator)	☐ Yes	☐ No	
High blood pressure	☐ Yes	☐ No	
High cholesterol	☐ Yes	☐ No	
Bleeding problems/Blood clots	☐ Yes	☐ No	
Balance problems	☐ Yes	☐ No	

Name: _____

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Name: _____ **Date of Birth:** _____

Numbness/tingling	☐ Yes	☐ No	
Blackout/fainting	☐ Yes	☐ No	
Psychological problems/Depression	☐ Yes	☐ No	
AIDS/Hepatitis	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No	
Arthritis/rheumatoid	☐ Yes	☐ No	
Weight loss/weight gain	☐ Yes	☐ No	
Epilepsy	☐ Yes	☐ No	
Migraines or headaches	☐ Yes	☐ No	
Skin, e.g., rashes, lesions, moles	☐ Yes	☐ No	
Fatigue	☐ Yes	☐ No	
Poor sleep	☐ Yes	☐ No	

Family History

Do any of your grandparents, parents, siblings,or children have any of the following diseases? Please explain.

Diabetes	☐ Yes	☐ No	
High blood pressure	☐ Yes	☐ No	
Heart attack	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No	
Arthritis	☐ Yes	☐ No	
Rheumatoid arthritis	☐ Yes	☐ No	
Back or neck problems	☐ Yes	☐ No	
Bleeding disorders	☐ Yes	☐ No	
Epilepsy	☐ Yes	☐ No	
Hepatitis	☐ Yes	☐ No	
Migraines/headaches	☐ Yes	☐ No	
Psychiatric problems	☐ Yes	☐ No	
Thyroid problems	☐ Yes	☐ No	

Social History

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Do you live alone? ☐ Yes ☐ No

☐ Employed (occupation _____) ☐ Student ☐ Retired

Children? ☐ Yes ☐ No Number: _____

Exercise? ☐ Never ☐ Rarely ☐ Weekly ☐ Daily

What type of exercise? _____

Smoking? ☐ Yes ☐ No _____ Packs per day for _____ years.

Quit smoking? ☐ Yes ☐ No When? _____

Previously smoked? ☐ Yes ☐ No _____ Packs per day for _____ years.

Chew tobacco? ☐ Yes ☐ No How much? _____

Drink alcohol? ☐ Yes ☐ No How much and how often? _____

Substance abuse? ☐ Yes ☐ No What? _____

Patient Signature _____ Date _____

Reviewed by _____ Date _____

MD Signature _____ Date _____

Printed: #######