HealthEast SPINE CENTER

PATIENT HEALTH HISTORY QUESTIONNAIRE

The following information is important to your plan of care. Please complete every section. Do not leave any blanks.

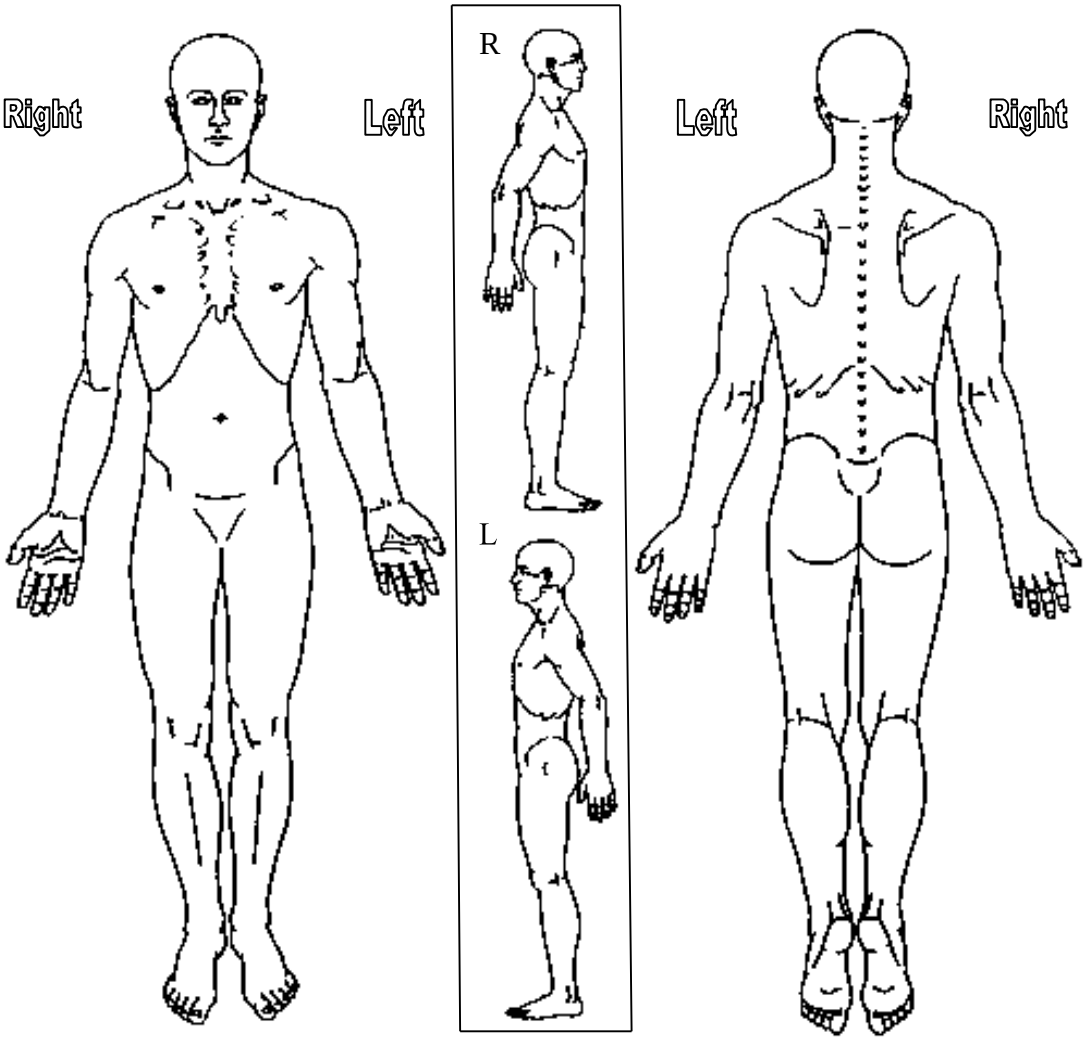
Please mark on the pain level that most accurately represents your pain

	NO PAIN										UNBEARABLE PAIN
Today's Pain	0	1	2	3	4	5	6	7	8	9	10
Worst Pain	0	1	2	3	4	5	6	7	8	9	10
Best Pain	0	1	2	3	4	5	6	7	8	9	10

Pain Diagram

Please mark the figure with the location of your symptoms as a result of this injury or accident:

Pain = X Numbness/Tingling = #



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WHAT DO YOU HOPE TO ACCOMPLISH IN TODAY'S VISIT?:_____

_____

_____

YOUR MEDICAL HISTORY

DO YOU HAVE NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES	NO
Coronary Artery Disease/Heart Attack		
Atrial fibrillation (A fib)		
Hypertension		
Hyperlipidemia		
Type I or II Diabetes		
Thyroid disease		
Asthma		
COPD/Emphysema		
Lung Disease		
Cancer		
Serious Infection		
Anemia		
Blood Clot		
HIV/AIDS		
Anxiety		
Depression		
Mental Disease		
Colitis		

	YES	NO
Irritable Bowel Syndrome		
Acid Reflux		
Stomach Ulcers		
Stroke		
Multiple Sclerosis		
Epilepsy/Seizures		
Neuropathy		
Enlarged Prostate		
Gout		
Osteoporosis		
Hepatitis/Liver disease		
Kidney disease		
Rheumatological Disease		
Rheumatoid arthritis		
Osteoarthritis		
Other:		

SURGICAL HISTORY (Please list all surgeries):_____

_____

_____

_____

FAMILY / SOCIAL HISTORY

DO YOU HAVE A FAMILY HISTORY OF:

	YES	NO	Relative:
Cancer			
Diabetes			
Heart Disease			
Hypertension			

	YES	NO	Relative:
Stroke			
Rheumatologic Disease			
Aneurysm			
Other:			

YOUR PERSONAL HABITS: Do you……	YES	NO	If YES, Please explain:
Smoke? / Use any tobacco products?			
Use alcohol?			
Were you ever a heavy drinker?			
Use recreational drugs?			

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MARITAL STATUS: Single Married Widowed Divorced

OCCUPATION:_____

EXERCISE HISTORY:_____

DRUG ALLERGIES or ADVERSE REACTIONS:_____

Review of Symptoms:

Have you recently been troubled with any of the following symptoms:

	YES	NO
GENERAL:		
Fever (temp > 101° F)		
Weight Gain		
Weight loss (> 10 lbs.)		
Sexual dysfunction		
EAR, NOSE, THROAT:		
Headache		
Hoarseness		
Ringing in ears		
Difficulty swallowing		
EYES:		
Changes in vision		
Eye pain		
Blindness		
HEART:		
Chest pain		
Palpitations		
Feet/leg swelling		
Color changes in hands/feet		
LUNGS:		
Shortness of Breath		
Cough		
Wheezing		
LYMPH NODES:		
Enlarged lymph nodes		
STOMACH (GI):		
Abdominal pain		
Diarrhea		
Constipation		
Nausea/vomiting		
Reflux		
Loss of bowel control		

	YES	NO
Blood in the stool		
RENAL (URINARY):		
Pain with urinating		
Difficulty urinating		
Loss of bladder control		
Blood in the urine		
MUSCLE/BONE:		
Joint pain		
Muscle pain		
Muscle fatigue		
Sciatica		
SKIN:		
Itching		
Open wounds		
Non healing wound		
BRAIN/NERVES:		
Imbalance (trips/stumbles)		
Falls		
Dizziness		
Fainting		
Seizures		
BLOOD DISORDERS:		
Sickle Cell anemia		
Hemophilia		
Excessive bleeding		
Easy bruising		
SLEEP/PSYCHOLOGICAL:		
Insomnia		
Excessive tiredness		
Anxiety		
Depression		
Suicidal ideas		

The above information is true and correct to the best of my belief.

_____ _____

Patient Signature (Parent or Guardian for Minor) & Date **Physician/APP Signature & Date**

CLINICAL ASSISTANT/REVIEWER INITIALS:_____