DEER VALLEY SPINE CENTER

PATIENT HISTORY

PATIENT NAME (LAST) (FIRST) (MIDDLE)	☐ MALE ☐ FEMALE	AGE	HEIGHT	WEIGHT

PATIENT MEDICAL HISTORY

Alcohol consumption?.......	☐Yes	☐No	CVA / Stroke……...	☐ Yes	☐ No	Jaundice…………...	☐ Yes	☐ No
How much?___________	___________		Depression………...	☐ Yes	☐ No	Kidney problems…..	☐ Yes	☐ No
Anemia…………………..	☐Yes	☐No	Diabetes…………...	☐ Yes	☐ No	Latex sensitive…….	☐ Yes	☐ No
Arthritis………………….	☐Yes	☐No	Dialysis……………	☐ Yes	☐ No	Pneumonia………...	☐ Yes	☐ No
Asthma…………………...	☐Yes	☐No	Emphysema……….	☐ Yes	☐ No	Sinusitis…………...	☐ Yes	☐ No
Bladder disorder…………	☐Yes	☐No	Epilepsy…………...	☐ Yes	☐ No	Sickle Cell…………	☐ Yes	☐ No
Bleeding disorder………..	☐Yes	☐No	Fainting spells…….	☐ Yes	☐ No	Smoking…………...	☐ Yes	☐ No
Bowel disorder…………..	☐Yes	☐No	Glaucoma…………	☐ Yes	☐ No	How much?______	___________	
Bronchitis………………..	☐Yes	☐No	Had a cold recently..	☐ Yes	☐ No	Stomach disorders...	☐ Yes	☐ No
Cancer…………………...	☐Yes	☐No	Hearing problems…	☐ Yes	☐ No	Thyroid problems…	☐ Yes	☐ No
Convulsions……………..	☐Yes	☐No	Hepatitis (B or C)...	☐ Yes	☐ No	Tremors/Parkinson's	☐ Yes	☐ No
Currently Pregnant……...	☐Yes	☐No	HIV/AIDS exposure	☐ Yes	☐ No			

Please list all current medications and dosages:____

____

Please list any medications that you have a history or allergic reaction to: (list what your reaction was):

____

____

Please list all previous surgeries: ____

____

CARDIOVASCULAR HISTORY

Do you have high blood pressure?..........	☐ Yes	☐ No	Do you have any heart disease?....................	☐ Yes	☐ No
Do you have palpitations?......................	☐ Yes	☐ No	Do you suffer from irregular heartbeats?......	☐ Yes	☐ No
Do you have fast heartbeats?.................	☐ Yes	☐ No	Do you suffer from angina?.........................	☐ Yes	☐ No
Do you have a heart murmur?................	☐ Yes	☐ No	Do you have a cardiac pacemaker?.............	☐ Yes	☐ No
Do you suffer from chest pain?..............	☐ Yes	☐ No	Have you ever had a stroke?.......................	☐ Yes	☐ No
Have you ever had a heart attack?..........	☐ Yes	☐ No			

FAMILY MEDICAL HISTORY

Please list any family medical history: (living or deceased) What family member?

Cancer………………………	☐ Yes	☐ No	Relation:______________________________	☐ Living	☐ Deceased
Heart disease………………...	☐ Yes	☐ No	Relation:______________________________	☐ Living	☐ Deceased
High blood pressure………….	☐ Yes	☐ No	Relation:______________________________	☐ Living	☐ Deceased
Diabetes……………………...	☐ Yes	☐ No	Relation:______________________________	☐ Living	☐ Deceased
Depression/Mental disorders...	☐ Yes	☐ No	Relation:______________________________	☐ Living	☐ Deceased
Other _________________________________			Relation:______________________________	☐ Living	☐ Deceased
Other _________________________________			Relation:______________________________	☐ Living	☐ Deceased
Other_________________________________			Relation:______________________________	☐ Living	☐ Deceased

PATIENT SIGNATURE	DATE