NJ Spine and Orthopedic

PATIENT HISTORY QUESTIONNAIRE

NAME: _____ AGE: _____ TODAY'S DATE: _____

REASON FOR TODAY'S VISIT: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS: YES ___ NO ___ LIST ANY MEDICATIONS THAT YOU AE ALLERGIC TO: ____

_____

PAST MEDICAL HISTORY CHECK YES OR NO DO NOT LEAVE ANY BLANKS

CONDITION:	YES	NO	CONDITION:	YES	NO
GALLSTONE_____	YES ___	NO ___	STROKE_____	YES ___	NO ___
PNEUMONIA/BRONCHITIS_____	YES ___	NO ___	LIVER DISEASE_____	YES ___	NO ___
HYPERTENSION_____	YES ___	NO ___	DIABETES_____	YES ___	NO ___
ANEMIA_____	YES ___	NO ___	EMPHYSEMA/ASTHMA____	YES ___	NO ___
HEART ATTACK_____	YES ___	NO ___	HEART MURMUR_____	YES ___	NO ___
TUBERCULOSIS_____	YES ___	NO ___	HEPATITIS_____	YES ___	NO ___
MITRAL VALVE PROLAPSE_____	YES ___	NO ___	ARTHRITIS_____	YES ___	NO ___
CANCER_____	YES ___	NO ___	KIDNEY DISEASE_____	YES ___	NO ___
INTERSTINAL DISEASE_____	YES ___	NO ___	WEIGHT LOSS_____	YES ___	NO ___
RHEUMATIC FEVER_____	YES ___	NO ___	LUNG DISEASE_____	YES ___	NO ___
BLOOD CLOTS LUNGS/LEGS_____	YES ___	NO ___	LUPUS_____	YES ___	NO ___
OTHER DISORDERS _____			_____		
_____	YES ___	NO ___	_____		

LIST ANY OTHER MEDICAL CONDITIONS THAT ARE NOT NOTED ABOVE: _____

_____

HAVE YOU HAD ANY SURGERIES: YES ___ NO ___ PLEASE LIST : _____

_____

_____

LIST ALL MEDICATION THAT YOUR CURRENTLY TAKING: *USE THE BACK OF THE PAGE IF NEEDED:*

MEDICATION *DOSE* *HOW OFTEN PER DAY* *REASON FOR TAKING*

_____

_____

_____

_____

ARE YOU RIGHT OR LEFT HANDED? _____ HEIGHT: _____ WEIGHT: _____

DO YOU SMOKE? YES___ NO ___ | PIPE ____ CIGAR ____ CHEWING TABACCO _____ HOW MUCH PER DAY _____

ARE YOU AN EX-SMOKER? YES___ NO ___ | IF YES, WHEN DID YOU QUIT? _____

DO YOU DRINK ALCOHOL? YES___ NO ___ | DAILY _____ WEEKLY _____ OCCASIONALLY _____

DATE OF LAST TETANUS SHOT: _____

FAMILY MEDICAL HISTORY

	CURRENT	*AGE*	*AGE OF DEATH*	*SIGNIFICANT MED. PROBLEM*
MOTHER				
FATHER				
SIBLING				