



SPURLOCK SPINE CENTRE

MEDICAL HISTORY

Today's Date: ____/____/____ Name: _____

Past History

1.) List any **surgeries** your have had (such as: appendix, ear tubes, pacemaker, wisdom teeth or any other surgically implanted device) and the year: None

_____/_____/_____
_____/_____/_____

2.) List any serious **illness** (such as: AIDS/HIV, cancer, diabetes, heart disease, etc.) and the year it began: None

_____/_____/_____
_____/_____/_____

3.) List any physical **injuries** (such as automobile accidents, broken or fractured bones, dislocations, falls, head injury, lacerations or significant cuts, strains or work injuries) and the year it happened: None

_____/_____/_____
_____/_____/_____

4.) List current **medications**, nutritional supplements and vitamins (prescription and over-the-counter) with dosage: None

_____/_____/_____
_____/_____/_____

Red Flags

- Do you have problems with recurring headaches? No Yes, _____
- Are you losing weight without trying? No Yes, _____
- Does your pain wake you up at night? No Yes, _____
- Have you had a change in bowel or bladder habits? No Yes, _____
- Have you had a sore that doesn't heal? No Yes, _____
- Have you recently had any unusual bleeding or discharge? No Yes, _____
- Do you have a thickening/lump in the breast or elsewhere? No Yes, _____
- Do you have indigestion or difficulty swallowing? No Yes, _____
- Have you had an obvious change in a wart or mole? No Yes, _____
- Do you have a nagging cough or hoarseness? No Yes, _____

Family History

5.) Father: Age: _____ or Age at Death: _____ Cause of Death: _____ Significant Illness: _____

Mother: Age: _____ or Age at Death: _____ Cause of Death: _____ Significant Illness: _____

Are there any diseases or conditions common among your family members? No Yes, which relative, and what type of condition? _____

Social History:

6.) Educational Level (highest level you attained):

- Grade School High School-GED College-No degree College-Postgraduate
- High School-No degree High School-Graduate College-Graduate

7.) Exercise: None Occasional Regular Frequent and Heavy

8.) Substance Usage: Alcohol: None Rarely Occasional Heavy Recovering Alcoholic/How Long? _____

Recreational Drugs: None Type Used: _____

Tobacco: None Cigarettes, packs per day: _____ Chews, pouches per week: _____

Dips, cans per week: _____ Previously smoked for: _____ years, and quit _____ years ago.

Caffeine: None Cups of coffee per day: _____ Sodas per day: _____

9.) Is there any chance that you are currently pregnant? No Yes, how far along? _____