SILVER SPINE & NEUROLOGICAL CENTER
ADULT BRAIN AND SPINE SURGERY

Health History Questionnaire

Full Name:____ **Date:** _____ / _____ / _____

Medical Allergies: ____________________ ____________________ ____________________ ____________________

Disease (check all that apply)	Self	Mom	Dad	Sis	Bro	GM	GF
Allergic Rhinitis/Hay Fever							
Anemia							
Arthritis							
Asthma							
Blood Transfusion							
Breast Cancer							
Cataracts							
Cancer & Type							
Depression							
Anxiety							
Mental Illness							
Diabetes							
Drug/Alcohol/Physical Abuse (Circle which apply)							
Emphysema							
Lung Problems							
Endometriosis							
Hearing Problems							
Heart Disease							
Heart Attack							
High Blood Pressure							
High Cholesterol							
Irritable Bowel Syndrome							
Kidney Problems							
Migraines							
Neurological Disease							
Peptic Ulcer Disease/GI Problems							
Positive TB Test/Tuberculosis							
Sexually Transmitted Disease							
Stroke							
Thyroid Problems							
Other							

Hospitalizations	
Reason:	Yr.
Reason:	Yr
Reason:	Yr
Reason:	Yr
Reason:	Yr
Surgeries	
	Yr
	Yr
	Yr
	Yr
	Yr
	Yr
	Yr
	Yr

Do you use any form of Tobacco?	
Yes	No
Type & Amount:	
Do you drink Alcoholic Beverages?	
Yes	No
Amount:	
Substance Abuse?	
Yes	No
Do you Live Alone?	

Current Medications	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Other Medication	Dosage	Frequency
1.		

I certify that the above information is correct and true to the best of my knowledge. I will not hold my doctor or any members of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: ________________________________ **Date**: ________ / _______ / ______