erlanger
Neurosurgery and Spine

Date: _____

HEALTH HISTORY

979 E. 3rd Street Suite C-920 Chattanooga, TN 37403 · Ph: (423) 778-2233 · Fax: (423) 756-8265

All information is treated as strictly confidential. The more fully you complete this form, the better we will be able to diagnose and treat you.

Name: _____ **DOB:** _____ **Age:** _____

Office Use Only: Temp_____ HR_____ BP_____ RR_____ HT_____ WT_____ BMI_____

What problem will we address today? _____

When did this start? Was there an event that caused this? _____

Where on your body does it bother you?_____

_____

Describe your symptoms: _____

_____

At its worst, how bad is your pain (scale of 1-10)?_____ At its best?_____

What makes it better? _____ Worse? _____

What medications have you taken for this problem? _____

OTCs (Tylenol/Acetaminophen, Ibuprofen, Aleve/Naprosyn, Aspirin, Goody/BC powder)

Topicals (Pain creams, diclofenac/Voltaren cream, Aspercreme, BenGay, lidocaine patches/cream)

Rx Anti Inflammatories (steroids, meloxicam/Mobic, ketorolac/Toradol, diclofenac, celecoxib/Celebrex)

Muscle relaxants (methocarbamol/Robaxin, tizanidine/Zanaflex, cyclobenzaprine/Flexeril, baclofen)

Nerve pain medicines (gabapentin/Neurontin, pregabalin/Lyrica, duloxetine/Cymbalta)

Opiates (codeine, tramadol, hydrocodone, oxycodone, morphine, methadone, fentanyl, buprenorphine)

Have you done physical therapy? When and for how long? _____

Have you had chiropractic care? When and for how long? _____

Have you had injections? From whom, when, and where? _____

What other treatments have you tried? _____

Are you considering surgery for this problem? _____

Is this related to a workplace or motor vehicle accident? _____

Anything else we should know? _____

_____

Do any of these additional problems apply to you (please circle)?

Constitutional:	Fatigue	Weight gain	Weight loss	Fevers	Seizures	Poor sleep
Psychiatric:	Psychiatric treatment		Depression	Anxiety	Bipolar	PTSD
Sensory:	Vision loss / Double vision		Hearing loss / Ringing in the ear		Dizziness	
Hormones:	Diabetes Type 1 or 2		Thyroid problems	Osteoporosis		
Gastrointestinal:	Nausea/Vomiting	Diarrhea	Constipation	Ulcers/GERD		
Blood:	Blood thinner use		Easy bruising / Free bleeder		Abnormal blood counts	
Bladder:	Incontinence	Frequent bladder infections				
Heart/Lungs:	Chest pain	Irregular heartbeat		CPAP / Oxygen use	COPD / Asthma	
Cancer:	Lung	Breast	Prostate	Skin	Lymphoma/Leukemia	

Does anyone in your family have a problem related to the one we are treating today?

FOR YOUR ALLERGIES, MEDICATIONS, MEDICAL & SURGICAL HISTORY YOU MAY ATTACH ADDITIONAL PAGES

ALLERGIES: Please list your medication allergies and the symptoms they cause

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MEDICATION: Please list your prescription medicines (not listed above)

	Medicine	Strength	How often?		Medicine	Strength	How often?
1				4			
2				5			
3				6			

PAST MEDICAL HISTORY: Please list your chronic medical conditions (not listed above)

1		4		
2		5		
3		6		

PAST SURGICAL HISTORY: Please list all surgeries you have had

	Surgery	Year	Complications?		Surgery	Year	Complications?
1				4			
2				5			
3				6			

SOCIAL HISTORY:

Occupation (indicate if disabled or retired) _____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Children: □ Yes □ No How Many_____

Do you smoke? □ Yes □ No Cigarettes _____packs per day for _____years

□ Cigars/Pipe □ Smokeless tobacco □ Vape/eCig

□ I quit smoking ____ years ago. I had smoked for __ years total.

How often do you drink alcohol? □ Never □ Rarely □ Socially □ Frequently