DARTMOUTH-HITCHCOCK MEDICAL CENTER
One Medical Center Drive
Lebanon, New Hampshire 03756

Spine Center
Patient Health History Questionnaire

In preparation for your upcoming appointment in the Spine Center, please take a few minutes to complete the following health history. Completion of this medical form in advance of your Spine Center appointment will help us provide the best possible care for your Spine condition.

Kindly remember to bring this completed medical form with you at the time of your appointment. Please give the completed form to the clinic staff person upon your placement in an examination room. You do not need to mail this form in advance.
Thank you.

PATIENT INFORMATION

Name: _____

Date of Birth : ___/ ___/ _____
mo day year

❑ **Male** ❑ **Female** **Height:**_____ **Weight:** _____

VISIT INFORMATION

Date of Visit: ___/ ___/ _____
mo day year

Referred by: ❑ **Referring Physician** **Name:** _____
❑ **Self-referred**

1. **Who is your regular / primary care doctor or nurse?** _____
2. **Reason for visit: (what is your problem?)** _____
_____
3. **Is this a work-related injury?** ❑ **No** ❑ **Yes; If yes, date of Injury** ___ / ___ / _____
mo day year
4. **Where do you/did you work?** _____
Type of Work: _____ ❑ **Student**
Please note any work modifications, such as light duty, part-time or other:
_____
If not working, date last worked: ___/ ___/ _____
mo day year
5. **Is this an injury resulting from a non-work-related accident?** ❑ **No** ❑ **Yes**

6. When did this episode of your symptoms/problem begin? Date: ___/ ___/ _____
mo day year

7. If known, please describe how your symptoms/problem began: _____

_____

_____

8. How long have you had spine problems? _____

9. For this problem have you had:

Physical Therapy ❑ No ❑ Yes, when?_____
Spinal Injections ❑ No ❑ Yes, when?_____

MEDICATIONS

Please list ALL the medications you are currently taking (include prescription, over-the counter non-prescription, herbs and vitamins). Please include the dose (strength), and how often you take it.

Name of Medication	Reason for taking	Dose	How often/when
Example: Synthroid	*Thyroid disorder*	*0.15mg*	*One time a day*

Are you currently on any blood thinning medication such as Coumadin, Warfarin, Heparin, Fragmin, Lovenox, Pletal, Aspirin? ❑ No ❑ Yes
Since When?_____ reason why?_____

ALLERGIES

Do you have allergies or sensitivities to any medicines, latex, food, or dye/contrast material?

❑ No ❑ Yes If YES, please list what you are allergic to, and what happened when you took it.

Allergy (Medication/Latex/food/contrast dye)	Type of Reaction

MEDICAL CONDITIONS

List below all the medical problems you have (for example: depression, heart or lung problems, high blood pressure, diabetes, fibromyalgia, ulcers, cancer, etc.).

Medical Problem	Date Problem Began

Have you ever had phlebitis, blood clots, or an embolism?_____

SURGERY

List below all surgeries/operations you have had and their dates.

Surgical Procedure	Date of Surgery

OTHER HEALTH FACTORS

1. Do you currently smoke? ❑ No ❑ Yes

If yes, how many packs per day? ____ For how may years? _____

If you are not currently smoking, have you smoked in the past? ❑ No ❑ Yes

2. **Do you drink alcohol (this includes beer, wine, and/or hard liquor)?** ❑ **No** ❑ **Yes**

   If yes, how much? _____

3. **Do you need assistance with your daily activities?** ❑ **No** ❑ **Yes**

4. **Do you use any of the following?** ❑ **Cane** ❑ **Walker** ❑ **Crutches** ❑ **Wheelchair**

5. **What do you expect from your Spine Center visit?** _____

   _____

   _____

FAMILY MEDICAL HISTORY

Has any relative ever had any of the following medical problems or conditions? If yes, please indicate the relationship to you (grandparent, parent, brother or sister, etc.).

- ❑ Diabetes
- ❑ Cancer
- ❑ Heart problems
- ❑ Spine problems
- ❑ Deep vein thrombosis (blood clots)
- ❑ Arthritis
- ❑ High Blood Pressure
- ❑ Stroke
- ❑ Congenital deformities
- ❑ Obesity
- ❑ Asthma
- ❑ Osteoporosis
- ❑ Frequent infections
- ❑ Tuberculosis
- ❑ Other

REVIEW OF SYSTEMS (To be completed by Spine Center health care provider)

Constitutional _____	ENT _____	Skin _____
Eyes _____	GI _____	Neuro _____
Cardiovasc _____	GU _____	Psych _____
Resp _____	Musculo _____	Endo _____
Heme/Lymph _____	All/Imune _____	All others neg. _____

_____ **Patient Signature/Date**

_____ **Reviewed by/Date**

WAA/dmg 6/06