Spine Institute of Louisiana
1500 Line Avenue
2nd Floor
Shreveport, LA 7110

Patient History Form

Chart #:_____

Name:_____ Date:_____
First Middle Last

DOB:_____ Sex:_____ Age:_____ Marital Status: S M W D
(Circle One)

Height:_____ Weight:_____ Occupation:_____

Primary Physician:_____

Chief Complaint:_____

_____

Any Known Drug Allergies:_____

List Current Medications:_____

_____

Family History:

Cause of Death:

Father: _____ Living _____ Deceased _____
Mother: _____ Living _____ Deceased _____
Siblings: _____# Living _____# Deceased _____
_____
Children: _____ # Living _____# Deceased _____

Do You have a Family History of:

Family Member:

Heart Disease	☐ No	☐ Yes	_____
High Blood Pressure	☐ No	☐ Yes	_____
Diabetes	☐ No	☐ Yes	_____
Stroke	☐ No	☐ Yes	_____
Cancer (Location)	☐ No	☐ Yes	_____
Thyroid Disease	☐ No	☐ Yes	_____

Other:_____

<u>WITHIN THE PAST 6 MONTHS</u> Have you had any of the following?

Please Explain:

Ulcers	☐ No	☐ Yes	_____
Colitis	☐ No	☐ Yes	_____
Rectal Bleeding	☐ No	☐ Yes	_____
Change in Bowel Habits	☐ No	☐ Yes	_____
Black Tarry Stools	☐ No	☐ Yes	_____
Heart Disease	☐ No	☐ Yes	_____
High Blood Pressure	☐ No	☐ Yes	_____
Chest Pain	☐ No	☐ Yes	_____
Cough Blood	☐ No	☐ Yes	_____

Shortness of Breath	No ☐	Yes ☐	_____
Thyroid Disease	No ☐	Yes ☐	_____
Lung Disease	No ☐	Yes ☐	_____
Cancer(Location)	No ☐	Yes ☐	_____
Asthma or Emphysema	No ☐	Yes ☐	_____
Hepatitis	No ☐	Yes ☐	_____
Jaundice or Liver Disease	No ☐	Yes ☐	_____
Gallbladder Disease	No ☐	Yes ☐	_____
Venereal Disease	No ☐	Yes ☐	_____
Kidney Stone(s)	No ☐	Yes ☐	_____
Blood in Urine	No ☐	Yes ☐	_____
Epilepsy	No ☐	Yes ☐	_____
Swollen or Painful Joints	No ☐	Yes ☐	_____
Nervous Disorder	No ☐	Yes ☐	_____
Depression	No ☐	Yes ☐	_____
Diabetes	No ☐	Yes ☐	_____
Stroke	No ☐	Yes ☐	_____
Back Disorder	No ☐	Yes ☐	_____
Blood Disease or Anemia	No ☐	Yes ☐	_____

Personal History

		Year	Hospital
Illnesses	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Surgeries	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Do you?			Please Explain
Regularly Exercise (3 to 4 times a week)	☐No	☐Yes	_____
Wear Auto Seat Belts (90% of the time)	☐No	☐Yes	_____
Use Illegal Drugs	☐No	☐Yes	_____
Use Alcohol	☐No	☐Yes	_____
Were You Ever a Heavy Drinker	☐No	☐Yes	_____
Smoke (if you quit, give date)	☐No	☐Yes	_____

Women Only

Menstrual Cycle: Are Periods Regular? ☐No ☐Yes Date of Last Period?_____

Age Onset:_____ Do You Have Difficulties With Periods?_____

Pregnancies: Describe Any Complications

_____ # Born Natural	_____
_____ # Cesarean Sections(s)	_____
_____ # Premature(s)	_____
_____ # Stillborn(s)	_____
_____ # Miscarriage(s)	_____