Spine And Pain Institute Of Nona
Your Path To Pain-free Living

Nona
SPINE AND PAIN INSTITUTE
RELIEVING PAIN, RESTORING LIFE

Health History

Please complete this Questionnaire.
It is designed to give us information about your
health, which will allow us to better understand and assist you.

Patient Name: _____ **DOB:** _____ **Sex:** ___ M ___ F

Weight: _____lbs. **Height:** ____ft ____in **Race:** _____ **Ethnicity:** _____

What is the main reason for your visit today? _____

Other Concerns:

_____

What are your health goals for the next year?

_____

REVIEW OF SYSTEMS: Please mark the box and /or circle any **persistent** symptoms you have had in the **past few months.** Read through every section and check "no problems" if none of the symptoms apply to you. List other concerns above.

General
___ Unexplained weight loss/ gain
___ Unexplained fatigue/ weakness
___ Fall asleep during day when sitting
___ Fever, Chills
___ *No Problems*

Gastrointestinal
___ Heartburn / reflux/ indigestion
___ Blood or change in bowels
___ Constipation
___ *No Problems*

Allergic/Immune
___ Hay fever/ allergies
___ Frequent infections
___ No Problems

Respiratory
___ Cough /wheeze
___ Loud Snoring/altered breathing during sleep
___ Short of breath with exertion
___ *No Problems*

Skin
___ New or change in mole
___ Rash /itching
___ *No Problems*

Genitourinary
___ Leaking urine
___Blood in urine
___ Nighttime urination or increased frequency
___ Discharge: penis or vagina
___Concern with sexual functions
___ *No Problems*

Hematologic/ Lymphatic
___ Swollen glands
___ Easy Bruising
___ *No Problems*

Neurological
___ Headache
___ Memory loss
___ Fainting
___ Dizziness
___ Numbness/tingling
___ Unsteady gait
___ Frequent infections
___ *No Problems*

Endocrine
___ Heat or cold sensitivity
___ *No Problems*

Psychiatric
__ Anxiety / stress /irritability
__ Sleep problem
__ Lack of concentration
__ *No Problems*

Cardiovascular
__ Chest Pain / discomfort
___ Palpitations
___ *No Problems*

Musculoskeletal
___ Neck Pain
___ Back Pain
___ Muscle /Joint Pain
___ *No Problems*

Breast
___ Breast lump/pain/nipple discharge
___ *No Problems*

Women Only
___ PMS Symptoms (bloating, cramps, irritable)
___ Problem with menstrual periods
___ Hot flashes / night sweats ___ No Problems

Eyes
___ Change in vision/ eye pain/ redness
___ *No Problems*

Immunizations: Check off any vaccinations you have had in the past. Add year if known.

Influenza (flu shot) _____ COVID19 _____

List ALL current medications:

Medication Name	Dose (milligrams, grams)	How many times per day?	How long?

Drug Allergies:

Drug	Type of Reaction?

Are you allergic to Latex? □ Yes □ No
Do you take Blood Thinners? (Coumadin, Plavix, Aggrenox, Ticlid, Pletal) □ Yes □ No

Name of Blood Thinner: _____ Prescriber Physician: _____

Women Only:
Bone Density Test Date: _____ **Abnormal:** □ Yes □ No

Social History & Status
Occupation: _____ Marital Status:_____ Highest Education: _____

Work Status
□ **Full Duty** □ **Light Duty** □ **Off Duty** (per physician) □ **Unemployed** □ **Retired**
If you are **not** working full duty, how long have you been off from work? _____
Have you had a work capacity assessment? □ **Yes** □ **No**
Are you disabled through Social Security? □ **Yes** □ **No**

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Tobacco Use

Do you currently use tobacco products? □ **Yes** □ **No** Age/Year Started: _____Age/Year Quit: _____

If yes, please indicate the quantity per day: **Cigarettes:** _____ **Cigars:** _____ **Chewing Tobacco:** _____

Alcohol Use

Do you currently consume alcoholic beverages? □ **Yes** □ **No**

Quantity per day? Beer: ____ Wine: ____ Spirits: ____

1. Have you ever felt you needed to cut down on your drinking? □ **Yes** □ **No**
2. Have people annoyed you by criticizing your drinking? □ **Yes** □ **No**
3. Have you ever felt guilty about drinking? □ **Yes** □ **No**
4. Have you ever felt you needed a drink first thing in the morning to steady your nerves, or to get rid of a hangover? □ **Yes** □ **No**

Have you ever been treated for a drug or alcohol addiction? □ **Yes** □ **No**

Personal Medical History

Do you currently have, or have you ever had, any of the following conditions?

Condition:	Code:	Current	Past	Comments
Alcohol/ Drug Abuse	305.00/305.90			
Allergy (Hay Fever)	477.9			
Anemia	285.9			
Anxiety	300.00			
Arthritis (Rheumatoid)	714.0			
Arthritis (Osteoarthritis)	715.90			
Asthma	493.90			
Bladder /Kidney Problems				
Blood Clot (Leg)	453.40			
Blood Clot (Lung)	415.11			
Blood Transfusion	V58.2			

Breast Lump (benign)	611.72			
Cancer Breast	174.9			
Cancer Colon	153.9			
Cancer Other Type				
Cancer Ovarian	183.0			
Cancer Prostate	185			
Cataracts	366.9			
Chicken Pox	052.9			
Colon Polyp	211.3			
Coronary Artery Disease	414.00			
Depression	311			
Diabetes (adult onset)	250.00			
Diabetes (childhood onset)	250.01			
Diverticulitis	562.10			
Emphysema	492.8			
Fractures (broken bones)				**Where?**
Gallbladder Disease	574.20			
GERD	530.81			
Glaucoma	365.9			
Gout	274.9			
Gynecological Cond. (Endometriosis)	617.9			

Gynecological Cond. (Fibroids)	218.9			
Gynecological Cond. (other)				
Heart Attack	410.90			
Hepatitis A	070.1			
Hepatitis B	070.30			
Hepatitis C	070.51			
Hepatitis Other	070.59			
High Blood Pressure	401.9			
High Cholesterol	272.0			
Hip Fracture	820.8			
Irritable Bowel Syndrome	564.1			
Kidney Disease/ Failure	586			
Kidney Stones	592.0			
Liver Disease	573.9			
Migraine Headaches	346.90			
Osteoporosis	733.00			
Pneumonia	486			
Prostate (enlargement)	600.00			
Prostate (nodules)	600.10			
Seizure / Epilepsy	780.39			
Skin Condition (Eczema)	692.9			

Skin Condition (Psoriasis)	696.1			
Skin Condition (Abnormal Moles)	238.2			
Sleep Apnea	780.57			
Stomach Ulcer	531.90			
Stroke	434.91			
Thyroid (Nodule)	241.0			
Thyroid High (Overactive)/ Hyperthyroidism	242.90			
Thyroid Low (Underactive) / Hypothyroidism	244.9			
Other (List)				
Other (List)				

SURGICAL HISTORY

Please check off any procedures or surgeries in your history. List any abnormal finding or complications.

Surgical Procedure	**Year**	**Comments:**
Abdominal Surgery		
Appendectomy (appendix removal)		
Back Surgery (lumbar)		
Biopsy (location)		
Breast Biopsy		□ **Right** □ **Left** □ **Both**
Breast Surgery		□ **Right** □ **Left** □ **Both**
Colonoscopy		

Coronary Bypass		
Coronary Stent's		
EGD (Stomach Endoscopy)		
Cataract		□ **Laparoscopic**
Gallbladder Removal		
Heart Surgery (other than coronary bypass)		
Hip Surgery		□ **Right** □ **Left** □ **Both**
Hysterectomy (total, including ovaries)		□ **Laparoscopic** □ **Vaginal** □ **Abdominal**
Hysterectomy (partial, ovaries left)		□ **Laparoscopic** □ **Vaginal** □ **Abdominal**
Knee Surgery		□ **Right** □ **Left** □ **Bilateral**
LEEP (Cervix Surgery)		
Neck Surgery (cervical)		
Ovary Ligation (tubal)		
Ovary Removal		□ **Right** □ **Left** □ **Bilateral**
Vasectomy		
Sigmoidscopy		
Sinus Surgery		
Other (list)		

Adopted? □ Yes □ No
If yes, and you do *not* know your family history, please skip the following section.

Family History
Please indicate which (if any) relatives have had the following diseases. Parents & siblings are most important.

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Disease	Mother	Father	Sister(s)	Bother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative
No Significant history known									
Alcoholism / Drug abuse									
Alzheimer's									
Asthma									
Autoimmune Disease									
Bleeding or Clotting Disorder									
Cancer Breast									
Cancer Colon									
Cancer Other Type									
Cancer Ovarian									
Cancer Prostate									
Colon Polyp									
Coronary Artery Disease									
Depression, Suicide, Anxiety									
Diabetes (childhood)									
Diabetes (Adult Onset)									
Emphysema (COPD)									

Genetic Disorder (Explain)									
Glaucoma									
Heart Disease (CHF)									
Heart Disease (Other)									
Hepatitis B or C									
High Blood Pressure hypertension									
High Cholesterol									
Hip Fracture									
Hypothyroidism/ Thyroid Disease									
Kidney Disease									
Macular Degeneration									
Migraine Headaches									
Osteoporosis									
Other (list)									

_____ _____

Patient Signature Date

Physician: