COMPREHENSIVE SPINE CARE, P.A.

DATE_____**NAME**_____**SEX**_____**AGE**_____

HEIGHT_____ **WEIGHT**_____ **DATE OF BIRTH**_____

SMOKER: YES NO AMOUNT PER DAY_____ **ALCOHOL:** YES NO HOW OFTEN_____

MEDICAL HISTORY:	YES	NO	**FAMILY:**	YES	NO
DIABETES	___	___		___	___
CANCER	___	___		___	___
HIGH BLOOD PRESSURE	___	___		___	___
ASTHMA	___	___		___	___
KIDNEY DISEASE	___	___		___	___
ULCERS	___	___		___	___
ARTHRITIS	___	___		___	___
DEPRESSION	___	___		___	___

ALLERGIES:	YES	NO	**NAME OF DRUG**	**REACTION**
ANTIBIOTICS	___	___	_____	_____
SHELLFISH/IODINE	___	___	_____	_____
MEDICATIONS	___	___	_____	_____
ANESTHESIA	___	___	_____	_____

MEDICATIONS PRESENTLY TAKING: _____

PAST SURGICAL PROCEDURES AND DATE: _____

COULD YOU BE PREGNANT TODAY? _____

FAMILY PHYSICIAN: _____ **ADDRESS:** _____ **PHONE:** _____

FAMILY HISTORY:	**ALIVE/WELL** (NUMBER OF EACH)	**DECEASED** (NATURE OF DEATH)
PARENTS	_____	_____
SIBLINGS	_____	_____
CHILDREN	_____	_____