South Texas SPINE & SURGICAL Hospital
*proudly owned & operated by physicians*

# Health Questionnaire
**(For nursing use only; not part of the medical record)**

What surgery are you having?_____

General information: Height_____ Weight_____

Have you had a flu vaccine? ☐ Yes (date _____) ☐ No

Have you had a pneumonia vaccine? ☐ Yes (date _____) ☐ No

Have you had a tetanus vaccine? ☐ Yes (date _____) ☐ No

## CARDIAC HISTORY

History of Cardiac Disorders? ☐ Yes ☐ No

If yes:
- ☐ Aneurysm
- ☐ Chest pain/angina
- ☐ Cardiac bypass surgery
- ☐ Congestive heart failure
- ☐ Clots in legs
- ☐ Heart Murmur
- ☐ Heart attack
- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ Irregular Heart Beat

Other: _____

## RESPIRATORY HISTORY

History of Respiratory Disorders? ☐ Yes ☐ No

If yes:
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Clot in lungs (pulmonary embolus)
- ☐ Pneumonia
- ☐ Sleep apnea

Do you use a CPAP at night when you sleep? ☐ Yes ☐ No

Other: _____

## NEUROLOGICAL HISTORY

History of Neurological Disorders? ☐ Yes ☐ No

If yes:
- ☐ Headaches
- ☐ Seizures
- ☐ Stroke or TIA (Any residual deficits?) _____
- ☐ Numbness or tingling to hands/feet ☐ Left ☐ Right
- ☐ Parkinson's
- ☐ Multiple sclerosis

Other: _____

## MUSCULOSKELETAL

History of Musculoskeletal Disorder? ☐ Yes ☐ No

If yes:
- ☐ Arthritis
- ☐ Chronic back pain
- ☐ Chronic neck pain
- ☐ Fibromyalgia
- ☐ Muscular dystrophy
- ☐ Osteoporosis

Other: _____

GASTROINTESTINAL

History of Gastrointestinal Disorders? ☐ Yes ☐ No

If yes: ☐ Crohn's disease ☐ Irritable bowel syndrome
☐ Diverticulitis/diverticulosis ☐ Reflux
☐ Hernia ☐ Ulcers
☐ Diverticulitis ☐ Gastrointestinal bleeding

Other: _____

URINARY

History of Urinary Disorders? ☐ Yes ☐ No

If yes: ☐ Bladder infections ☐ Prostate disease (BPH/Enlarged prostate)
☐ Dialysis ☐ Renal disease
☐ Incontinence ☐ Urinary retention
☐ Kidney stones

Other: _____

GYNECOLOGICAL

Are you or could you be pregnant at this time? ☐ Yes ☐ No LMP:_____

Do you have any gynecological disorders such as fibroids, cysts or amenorrhea? _____

EENT

Allergies: ☐ No ☐ Yes (Please list with the reaction)

_____

Vision/hearing problems: _____

ENDOCRINE

Are you diabetic? ☐ No ☐ Yes, Type I DM ☐ Yes, Type II DM

INTEGUMENTARY

Do you have any skin conditions, including eczema or psoriasis? Please list:

_____

BLOOD DISORDERS

History of blood disorders?

☐ Anemia ☐ Clotting disorders
☐ Other:_____

CANCER

History of Cancer? ☐ Yes ☐ No

If yes: ☐ Skin ☐ Prostate ☐ Bone
☐ Breast ☐ Colon ☐ Lung
☐ Leukemia ☐ Other:_____

OTHER MEDICAL INFORMATION

Do you have any history of TB, HIV, Hepatitis or MRSA? ☐ Yes ☐ No

Please list any surgeries: _____

_____

If yes, did you have any trouble with anesthesia? ☐ Yes ☐ No

FAMILY HISTORY

| | Mother | Father | Sibling | Other | Unknown |
|---|---|---|---|---|---|
| Cardiac Disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ | ☐ | ☐ |
| Malignant Hyperthermia | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ | ☐ |

Other: _____

Smoking Status:

☐ Current Everyday ☐ Current Someday Smoker ☐ Former Smoker ☐ Never

How much alcohol do you drink? ☐ None ☐ 1-2 per week ☐ >2 per week ☐ Daily

Do you take any recreational drugs? ☐ Yes ☐ No

Do you have any history or depression, anxiety or psychological disorder? ☐ Yes ☐ No

PRIMARY CARE PHYSICAN

Primary care physician name: _____

Primary care physician phone: _____

PREFERRED PHARMACY

Pharmacy name: _____ Phone: _____

Address: _____ Zip code: _____

PATIENT PORTAL

Email: _____