South Texas SPINE & SURGICAL Hospital
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{ Place Patient Label Here }

Health Questionnaire

(For OFFICE use only) DOS:_____ Arrival Time:_____

What surgery are you having? _____

General information: Height_____ Weight_____

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

Do you have any medication allergies? ☐ Yes ☐ No Medication adverse reactions? ☐ Yes ☐ No

If **yes**, please list (include side effects): _____

CARDIAC

History of Cardiac Disorders? ☐ Yes ☐ No

If yes: ☐ Aneurysm ☐ Chest pain/angina ☐ Pacemaker ☐ Heart Murmur
☐ Congestive heart failure ☐ High blood pressure ☐ Irregular Heart Beat
☐ High Cholesterol ☐ Heart attack - When? _____
☐ Cardiac bypass surgery - # vessels _____ ☐ Angiogram/Stents: # of stents _____
☐ Other: _____

RESPIRATORY

History of Respiratory Disorders? ☐ Yes ☐ No

History of Sleep Apnea? ☐ Yes ☐ No

If yes: ☐ Asthma ☐ Bronchitis ☐ Emphysema
☐ COPD ☐ Pneumonia ☐ Clot in lungs (pulmonary embolus)
☐ Other: _____

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

If **yes, please bring CPAP on the day of your surgery, if you will be staying overnight.

Have you ever been diagnosed with COVID? ☐ Yes ☐ No

If yes, were you hospitalized due to COVID? ☐ Yes ☐ No

Comment: _____

SLEEP APNEA SCREEN/RISK

Do you Snore loudly? (louder than talking) ☐ Yes ☐ No

Do you often feel tired, fatigued or sleepy in the daytime? ☐ Yes ☐ No

Has anyone observed you stop breathing while sleeping? ☐ Yes ☐ No

Do you have high blood pressure? ☐ Yes ☐ No

If **yes**, do you take 2 or more HTN meds? ☐ Yes ☐ No

Have you ever been diagnosed with type II diabetes? ☐ Yes ☐ No

BMI over 35? ☐ Yes ☐ No

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Age over 50 years old? ☐ Yes ☐ No

Neck circumference large or shirt size > 17.5 inches? ☐ Yes ☐ No

Male Gender? ☐ Yes ☐ No

NEUROLOGICAL (Brain/Spinal cord)

History of Neurological Disorders? ☐ Yes ☐ No

If yes: ☐ Alzheimer's ☐ Dementia ☐ Parkinson's ☐ Paralysis (Quadra or Paraplegia)
☐ Headaches ☐ Seizures ☐ Multiple sclerosis
☐ Neuropathy ☐ Stroke ☐ TIA (Any residual deficits?) _____
☐ Numbness or tingling to hand ☐ Left ☐ Right
☐ Numbness or tingling to feet ☐ Left ☐ Right
☐ Other: _____

MUSCULOSKELETAL (Bones/Muscles/Ligament/Tendons/Joints)

History of Musculoskeletal Disorder? ☐ Yes ☐ No

If yes: ☐ Arthritis ☐ Rheumatoid Arthritis ☐ Fibromyalgia
☐ Osteoporosis ☐ Chronic **back** pain ☐ Muscular Dystrophy
☐ Chronic **neck** pain ☐ Gout ☐ Other: _____

GASTROINTESTINAL (Digestive/Esophagus/Stomach/Colon/Rectum)

History of Gastrointestinal Disorders? ☐ Yes ☐ No

If yes: ☐ Cirrhosis ☐ Crohn's disease ☐ Hiatal Hernia
☐ Irritable bowel syndrome ☐ Diverticulitis ☐ Diverticulosis
☐ Pancreatitis ☐ Peptic Ulcer(s) ☐ Ulcerative Colitis
☐ GERD ☐ Gastrointestinal bleeding ☐ Other: _____

URINARY (Kidney/Bladder)

History of Urinary Disorders? ☐ Yes ☐ No

If yes: ☐ Prostate disease (BPH/Enlarged prostate) ☐ Cystitis
☐ Dialysis ☐ Urinary retention ☐ Kidney stones
☐ Chronic renal disease ☐ Incontinence ☐ UTI chronic
☐ Self-Catherization ☐ Other: _____

REPRODUCTIVE

Pregnant? ☐ Yes ☐ No LMP:_____ Breastfeeding? ☐ Yes ☐ No

Health Questionnaire

History of Reproductive Disorders? ☐ Yes ☐ No

If yes: ☐ Abnormal Pap ☐ Fibroids ☐ Irregular bleeding
☐ Ovarian Cyst ☐ STD ☐ Endometriosis
☐ Menstrual Disorder ☐ Menopause ☐ Low Testosterone
☐ Erectile Dysfunction ☐ Other: _____

EENT (Eyes/Ears/Nose/Throat)

History of EENT Disorders? ☐ Yes ☐ No

If yes: ☐ Seasonal Allergies ☐ Hearing loss ☐ Glaucoma
☐ Cataract- Left ☐ Hearing device- Left ☐ Chronic Sinusitis
☐ Cataract- Right ☐ Hearing device- Right ☐ Other: _____

ENDOCRINE (Diabetes/Thyroid/Pancreas)

History of Endocrine Disorders? ☐ Yes ☐ No

History of Diabetes Mellitus? ☐ Yes ☐ No

If yes: ☐ DM Type I ☐ DM Type II ☐ Hashimoto's
☐ Hyperthyroidism ☐ **Hypo**thyroidism ☐ Addison's
☐ Cushing ☐ Graves' ☐ Other: _____

INTEGUMENTARY (Skin/Nails)

History of Integumentary Disorders? ☐ Yes ☐ No

If yes: ☐ Cellulitis ☐ Eczema ☐ Shingles ☐ Rosacea
☐ Contact Dermatitis ☐ Psoriasis ☐ Other: _____

BLOOD

History of blood disorders? ☐ Yes ☐ No

If yes: ☐ Anemia ☐ Hemophilia ☐ Sickle Cell
☐ Clotting problems ☐ Other: _____

CANCER

History of Cancer? ☐ Yes ☐ No

If yes: ☐ Breast ☐ Liver ☐ Prostate ☐ Skin
☐ Lung ☐ Leukemia ☐ Kidney ☐ Ovarian
☐ Colon ☐ Cervical ☐ Uterine ☐ Other: _____

INFECTIOUS DISEASE

History of Infectious disease? ☐ Yes ☐ No

If yes: ☐ AIDS ☐ HIV ☐ Hepatitis A/B/C ☐ HPV

☐ Herpes ☐ Tuberculosis ☐ MRSA/VRE (resistant org) ☐ Other: _____

MEDICAL PROCEDURES

History of Surgery? ☐ Yes ☐ No History of Invasive Procedure? ☐ Yes ☐ No

If **yes**, please list: _____

_____

Did you have any trouble with anesthesia? ☐ Yes ☐ No

If **yes,** please list: _____

FAMILY HISTORY

	Mother	Father	Sibling	Other	Unknown
Cardiac Disease	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Malignant Hyperthermia	☐	☐	☐	☐	☐
Stroke (CVA/TIA)	☐	☐	☐	☐	☐

Other: _____

SMOKING/ALCOHOL STATUS

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

Amount of tobacco used? _____ Frequency of tobacco use? _____

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

Do you take any recreational drugs? ☐ Yes ☐ No

PSYCHOLOGICAL

History of Psychological Disorders? ☐ Yes ☐ No

If yes: ☐ ADD ☐ Depression ☐ Panic Disorder

☐ ADHD ☐ Bipolar Disorder ☐ PTSD

☐ Anxiety ☐ Schizophrenia ☐ Other: _____

ABUSE/HUMAN TRAFFICKING SCREENING

Do you have any concerns about your safety at home? ☐ Yes ☐ No

Have you been physically hurt or threatened by anyone? ☐ Yes ☐ No

Are you being forced to do anything you do not want to do? ☐ Yes ☐ No

Has your ID or documentation been taken from you? ☐ Yes ☐ No

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Are there any safety issues you would like addressed while you are here in the hospital? ☐ Yes ☐ No

Were any of the above questions answered yes? ☐ Yes ☐ No

SUICIDE BEHAVIORS QUESTIONNAIRE

1. Over the past 2 weeks, have you felt down, depressed, or hopeless?
    - Yes
    - No
    - Patient unable to complete
    - Patient refused
2. Over the past 2 weeks, have you had thoughts of killing yourself?
    - Yes
    - No
    - Patient unable to complete
    - Patient
3. In your lifetime, have you ever attempted to kill yourself?
    - Yes
    - No
    - Patient unable to complete
    - Patient
4. If response to question #3 is YES:
    - Within the last 24 hours
    - Within the last month
    - Between 1 and 6 months ago
    - More than 6 months ago
    - Patient unable to complete
    - Patient refused

PRIMARY CARE PHYSICAN

Name and Phone: _____

LOCAL PREFERRED PHARMACY

Pharmacy name: _____ Phone: _____

Address: _____ Zip code: _____

PATIENT PORTAL

Email: _____

(For OFFICE use only) B/P_____R_____HR_____SPO2_____TEMP_____

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Physician Notified for Abnormal Values-_____ _____ Reported to: _____

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~~Health Questionnaire~~

PATIENT MEDICATION LIST

Date: _____ Form Completed by: _____

Name of Medicine	DOSE	HOW OFTEN DO YOU TAKE IT	REASON FOR MEDICATION