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

Health Questionnaire

{ Place Patient Label Here }

(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

If you are age 65+, Have you had a Pneumonia vaccine? □ Yes (date _____) □ No

Other Vaccines Received and Date(s): _____

_____

_____

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 Heartbeat □ Afib
□ 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

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

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: _____

Do you have an Implanted Insulin Pump? □ Yes □ No
Make/Model of Pump: _____ Type/Name of Insulin Used: _____
Basal Rate: _____ Bolus Settings: _____
Target Blood Glucose Range: _____
Do you wear a Continuous Glucose Monitoring System? □ Yes □ No _____

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: _____

HEALTH RELATED SOCIAL NEEDS SCREENING

In the past month have you:

Skipped medications to save money? □ Yes □ No
Had any difficulty with housing? □ Yes □ No
Had any difficulty getting food? □ Yes □ No
Had any difficulty with transportation? □ Yes □ No
Had any difficulty paying for utilities? □ Yes □ No
Were any of the above questions answered yes? □ Yes □ No

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

- o More than 6 months ago
- o Patient unable to complete
- o Patient refused

PRIMARY CARE PHYSICAN

Name and Phone: _____

LOCAL PREFERRED PHARMACY

Pharmacy Name: _____ Phone: _____

Address: _____ Zip Code: _____

PATIENT PORTAL ACCESS

Email: _____

CHG Education Provided: □ Yes □ No _____

(For OFFICE use only): B/P_____R_____HR_____SPO2_____TEMP_____

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

PATIENT MEDICATION LIST

Date: _____ Form Completed by: _____

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