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): _____

Have you fallen in the last 6 months? ☐ Yes ☐ No

FOR HIP & KNEE REPLACEMENT

How comfortable are you filling out medical forms by yourself?

☐ Not at all ☐ Somewhat ☐ Extremely
☐ A little bit ☐ Quite a bit

Have you taken for pain medication consistently of the last 90 days or more? ☐ Yes ☐ No
(Ex: Hydrocodone, Tramadol, Oxycodone, etc.)

What amount of pain have you experienced in the last week in your other knee/hip?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

My BACK PAIN at the moment is:

☐ None ☐ Moderate ☐ Very Severe
☐ Very Mild ☐ Fairly Severe ☐ The Worst Pain Imaginable

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 - # of 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 have diagnosed Sleep Apnea? ☐ Yes ☐ No
Do you Snore loudly? (louder than talking) ☐ Yes ☐ No
Do you often wake up feeling as tired as you were when you went to bed? ☐ Yes ☐ No
Has anyone observed you stop breathing while sleeping for more than 10 seconds? ☐ Yes ☐ No
Do you have or are you being treated for high blood pressure? ☐ Yes ☐ No
BMI over 35? ☐ Yes ☐ No
Age over 50 years old? ☐ Yes ☐ No
Neck circumference large or shirt collar size > 17" inches(male)/ 16" (female)? ☐ 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-Catheterization ☐ Frequency ☐ Other: _____

Have you ever had a urinary catheter or been catheterized? ☐ Yes ☐ No
If yes, were there any issue with the catheterization? ☐ Yes ☐ No
If yes, please explain: _____

REPRODUCTIVE

MEN:

History of Reproductive Disorders? ☐ Yes ☐ No
If yes: ☐ Low Testosterone ☐ Erectile Dysfunction ☐ Other: _____

WOMEN:

Pregnant? ☐ Yes ☐ No Breastfeeding? ☐ Yes ☐ No
Last Menstrual Period: _____
History of Reproductive Disorders? ☐ Yes ☐ No
If yes: ☐ Abnormal Pap ☐ Fibroids ☐ Irregular bleeding
☐ Ovarian Cyst ☐ STD ☐ Endometriosis
☐ Menstrual Disorder ☐ Menopause ☐ 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
☐ Cushings ☐ 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/VAPING/ALCOHOL STATUS

☐ Smoking ☐Vaping
☐ Current Everyday ☐ Current Someday ☐ Former ☐ Never
Do you live/work in a smoking environment? ☐ Yes ☐ No
Type of product(s): _____
Number of tobacco/vaping used per day: _____
Number of years of tobacco/vaping use: _____
Do you drink alcohol? ☐ Yes ☐ No
Type of alcohol: _____
How much alcohol do you drink? ☐ None ☐ 1-2 per week ☐ >2 per week ☐ Daily: _____ drinks
Number of years of alcohol use: _____
Do you take any recreational drugs? ☐ Yes ☐ No
Discuss type of drugs/frequency/years of use: _____

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
Are there any safety issues you would like addressed while you are here in the hospital? ☐ 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 refused
3. In your lifetime, have you ever attempted to kill yourself?
   - Yes
   - No
   - Patient unable to complete
   - Patient refused
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 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