HORIZON
Spine and Pain Specialists

Patient History

Patient name: ____ **Date of birth:** ______________________

Appointment Date and Time: ____

Height: ____________________________ **Weight:**_____________________________

Do you have someone to drive you home: ☐Yes ☐No

When was your last MRI: ____

Where was it performed:____

Medical conditions (past and/or current)**:**

- ☐ None
- ☐ Abnormal heart rate/rhythm
- ☐ Blood clots
- ☐ Heart attack
- ☐ Stroke or “mini” stroke
- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypo-/Hyper-thyroidism
- ☐ Reflux
- ☐ Seizures
- ☐ Asthma/COPD/Emphysema
- ☐ Kidney disease
- ☐ Cancer
- ☐ History of falls
- ☐ Osteoporosis/Osteopenia
- ☐ Other:____

Any chance of pregnancy? ☐Yes ☐No ☐Maybe

Past surgeries or procedures:

____

____

____

Past hospitalization reason other than surgeries:

____

____

____

Do you use any of the following: ☐none ☐cane ☐walker ☐crutches ☐wheelchair

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Medications (Prescription and Over the Counter):
(if you run out of space, please add additional medications to the back of the page)

1. Name:__________________________ Frequency:________________________ Dose:_____________
2. Name:__________________________ Frequency:________________________ Dose:_____________
3. Name:__________________________ Frequency:________________________ Dose:_____________
4. Name:__________________________ Frequency:________________________ Dose:_____________
5. Name:__________________________ Frequency:________________________ Dose:_____________

Allergic to:

☐ None
☐ Shellfish
☐ Betadine
☐ Dye used in diagnostic tests
☐ Latex
☐ Bandaids/Tape
☐ Other:____

Previous Treatments:

☐ None
☐ Physical therapy
☐ Chiropractor
☐ Acupuncture
☐ Massage
☐ TENS
☐ Injections (neck or back)

Which treatments were helpful?

____

Marital Status:

☐ Single
☐ Significant Other
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

Occupation: ____

☐ Full-time
☐ Part-time
☐ Retired
☐ Unemployed
☐ Temporarily Disabled
☐ Permanently Disabled

Tobacco use:

☐ Never
☐ Less than 1 pack/day
☐ 2 or more packs/day
☐ Ex-smoker

Illicit drug use:

☐ Never
☐ Currently
☐ Past

Exercise:

☐ None
☐ Daily
☐ 2-3 times/week
☐ 4-5 times/week

Type of exercise:____