

Patient's name _____ Date of Birth _____ Sex: M or F

PAST PATIENT/ FAMILY MEDICAL HISTORY

C =patient currently receiving treatment P =patient past history – no current treatment F =Family history (Circle all that are applicable)
Have you or members of your immediate family had the following illnesses or problems? If so, explain any circled items.

anxiety	C	P	F	breathing / lung problems	C	P	F	high cholesterol	C	P	F
alcoholism	C	P	F	positive TB skin test	C	P	F	immune system problems	C	P	F
anemia	C	P	F	chronic cough	C	P	F	broken bones	C	P	F
asthma	C	P	F	tuberculosis	C	P	F	difficulty walking	C	P	F
confused	C	P	F	stomach problems	C	P	F	frequent falls	C	P	F
unresponsive	C	P	F	weight loss / gain	C	P	F	seizures /epilepsy	C	P	F
eyes / vision	C	P	F	bladder / kidney disorder/ dialysis	C	P	F	weakness	C	P	F
glaucoma	C	P	F	problems with reproductive organs	C	P	F	too little sleep	C	P	F
ears / hearing	C	P	F	bowel problems	C	P	F	too much sleep	C	P	F
nose	C	P	F	gallbladder	C	P	F	genetic disease	C	P	F
mouth	C	P	F	liver problems / hepatitis	C	P	F	migraine	C	P	F
sinus	C	P	F	circulation problems	C	P	F	mental illness	C	P	F
speech	C	P	F	blood clots	C	P	F	depression	C	P	F
throat	C	P	F	bleeding disorders	C	P	F	cancer, location	C	P	F
skin problems	C	P	F	stroke	C	P	F	pain: location	C	P	F
rash / eczema	C	P	F	high blood pressure	C	P	F	problems with anesthesia? explain	C	P	F
hives	C	P	F	heart disease/ problems	C	P	F	previous blood transfusion, adverse reaction? describe:	C	P	F
arthritis	C	P	F	rheumatic fever	C	P	F	Other illness (specify)	C	P	F
emphysema	C	P	F	thyroid	C	P	F		C	P	F
COPD	C	P	F	diabetes	C	P	F				

Explained any circled items: _____

Right or left handed? _____ Implants / surgical or other metal inside the body? if yes, type _____ location _____

List any previous hospitalizations / surgeries / invasive procedures: _____

Allergies – include the type of reaction _____

Nutritional status: What is your diet at home? (i.e. regular, low salt diabetic) _____ Do you need diet instructions? yes no
Have you had a large weight change (ex. 15 lbs) in the past 6 months? yes no If yes, gain loss

Psychological Status: Are you concerned about your level of anxiety and or coping ability? yes no if yes, explain _____

SOCIAL HISTORY

Marital Status : _____ Children (list names): _____

Do you live alone? yes no If you needed help to care for yourself, is there someone available to help you? yes no

Tobacco: yes no If yes, how much /day _____ x _____ years Recreational drugs: yes no

Alcohol: yes no If yes, how much /day _____ day, _____ week Caffeine: yes no If yes, how much / day _____

Exercise routine: _____ Occupation _____

Work related injury? yes no Pending lawsuit? yes no Currently working? yes no If no, last day worked _____

MVA? yes no if yes, Driver yes no Passenger? yes no Seatbelt? yes no Shoulder strap? yes no

Airbags deployed? yes no Injuries? yes no Unusual dietary habits or herbal supplements: _____

Do you need any information on services available? yes no specify _____

Special medical equipment /supplies (i.e. dentures, hearing aid, wheelchair, walker, oxygen, Hickman, implanted device): _____

Do you have an advance directive? Yes No If yes, living will, durable power of attorney, health care directive.
Would you like information about advance directives? Yes No {Staff Use : Brochure given date/ initials _____}

FACTORS THAT MAY AFFECT LEARNING

Who is to be taught: patient other; if other, relationship to patient _____ Able to read: yes no with difficulty
Comments _____ Potential barriers to learning: none blind poor vision deaf decreased hearing unable to talk learning disability inability to understand memory loss language, if other than English _____

Learns best by: reading verbal instruction practicing talking watching other, _____
Are there any cultural or religious beliefs that need to be considered in the care? yes no. If yes, _____

Signature _____ Relationship to patient _____ Date _____

Staff review date & signature/ initials _____
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