Coastal Spine and Rehab Center

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Medical Family History

Do you have chest pain?	Yes	No
Do you have indigestion?	Yes	No
Do you have headaches for hours or days?	Yes	No
Do you have blurred vision?	Yes	No
Do you have pain in neck, jaw or face?	Yes	No
Do you have vertigo (dizziness)?	Yes	No
Do you have any visual disturbances?	Yes	No
Do you have any ringing in your ears?	Yes	No
Do you pass out easily (faint)?	Yes	No
Do you take birth control pills?	Yes	No
Do you have a history of stroke in your family?	Yes	No

What prescription medication are you taking if any?
( ) High blood pressure medication
( ) Blood thinners
( ) Other_____
( ) List allergies or adverse reactions to medications _____

Have you ever had cancer?	Yes	No
Does your pain ever wake you from a sound sleep?	Yes	No
Have you had any loss of bladder or bowel control?	Yes	No
Have you lost consciousness or had double vision recently?	Yes	No
Are you seeing any other doctor now for any reason?	Yes	No

Note: _____

Are you taking any medications or over-the-counter drugs?	Yes	No

Please indicate type (aspirin, etc.) _____
What was the date of your last menstruation? _____

SOCIAL HISTORY

SMOKER ____YES or ____NO, If Yes, How many packs_____
ALCOHOL ____YES or ____NO, If Yes, How much_____

FAMILY HISTORY

Did you or your mother or father have any of the following:
Put an **S** for self**, M** for mother, **F** for father, and **A** for all

( ) High Blood Pressure	( ) Ulcer or Stomach Problems	( ) HIV Positive
( ) Heart Attack	( ) Stroke	( ) Pacemaker
( ) Emphysema	( ) Arthritis-Rheumatism	( ) Thyroid Disease
( ) Seizures-Convulsions	( ) Mental Illness	( ) Circulation Problems
( ) Asthma	( ) Diabetes	( ) Cancer
( ) Kidney Disease	( ) Osteoporosis	