MUNSON MEDICAL CENTER
Spine & Nerve Pain Treatment

Form #6769 (5/07)

Patient Name:_____
Date of Birth:_____

Completed by: ❒ Patient ❒ Family Member ❒ Nurse ❒ Old Records ❒ Other _____
Patient unable to complete due to: ❒ Critically ill ❒ Altered mental status ❒ Other _____

1. HISTORY Check all that apply or have applied to you.

Neurologic
❒ Headache ❒ Seizure_____
❒ Dizziness ❒ Fainting_____
❒ Weakness ❒ Numbness_____
❒ Stroke ❒ TIA ❒ Head Injury _____

Cardiovascular
❒ Chest Pain / Tightness / Pressure / Weight on Chest
❒ Ankle Swelling
❒ Murmur / Antibiotic need?_____
❒ Palpitations
❒ Irregular heart beat _____
❒ Easy bleeding ❒ Bruising
❒ Peripheral Vascular Disease
❒ Circulatory Problems
❒ Congestive Heart Failure_____
❒ Heart Disease_____
❒ Heart Attack (when)_____
❒ Internal Defibrillator ❒ Pacemaker
❒ Angioplasty_____ ❒ Stent_____
❒ Valve replacement____ ❒ CABG____
❒ High Blood Pressure ❒ High Cholesterol

Pulmonary
❒ Breathing Problems ❒ Short of Breath
❒ Pneumonia ❒ Pleurisy
❒ Cough - Productive? ❒ Yes ❒ No
❒ Mucus Changes
❒ Sleep Apnea ❒ CPAP_____
❒ Asthma ❒ Emphysema

Gastrointestinal - Hepatic
❒ Nausea ❒ Vomiting
❒ Abdominal Pain
❒ Weight loss _____lbs
❒ Weight gain_____lbs
❒ Diarrhea ❒ Constipation
❒ Black ❒ Bloody stool
❒ Ulcer ❒ Digestive problem
❒ Reflux ❒ Bloating
❒ Swallowing Difficulty
❒ Hiatal Hernia ❒Liver Disease
❒ Hepatitis B ❒ Hepatitis C
❒ Jaundice

Genitourinary
❒ Dialysis - last:_____
❒ Kidney Disease ❒ Kidney Stone

Other
❒ Bleeding Disorder ❒ Clotting Problem
❒ Anemia ❒ Rubella
❒ HIV ❒ AIDS
❒ Cancer / Tumor (site)_____
❒ Chemotherapy ❒ Radiation
❒ Depression ❒ Attempted Suicide
❒ Alcoholism ❒ Drug Abuse
❒ Infections difficult to treat
❒ MRSA ❒ VRE
❒ Diabetes
❒ Abnormally low blood sugar
❒ Thyroid Problems

Musculoskeletal
❒ Joint pain ❒ Arthritis
❒ Limited motion / Location_____
❒ Back pain ❒ Neck pain
❒ Fractures ❒ Contractures
❒ Prostheses
❒ Limb pain

Female Reproductive
❒ Are you pregnant? LMP_____

Anesthesia/Surgical
❒ Previous anesthesia problem
_____
❒ Family anesthesia problem
❒ Limitation of neck/jaw movement

List hospitalizations & surgeries (give dates):
_____
_____
_____
_____
_____
_____

FAMILY HISTORY(indicate who)
❒ Heart Disease_____
❒ Cancer_____
❒ Stroke_____
❒ Diabetes_____
❒ High Blood Pressure_____
❒ Depression ❒ Alcoholism ❒ Suicide

2. PAIN MANAGEMENT See chart

3. FUNCTIONAL ASSESSMENT:
Do you function independently at home? ❒ Yes ❒ No - comment_____
Do you need assistance with daily activities? ❒ Yes ❒ No - comment_____

4. SOCIAL HISTORY
Do/Did you smoke? ❒ No If yes, PPD?_____ How long?_____ Date quit?_____ Are you exposed to second-hand smoke? ❒ Yes ❒ No
Do you consume alcohol? ❒ No If yes, drinks per day?_____ Last drink?_____ Do you drink caffeine? If yes, cups per day?_____
Do you use recreational drugs? ❒ No If yes, list_____
Do you live alone? ❒ Yes ❒ No Who is your support person?_____
Do you have needs related to your spiritual / cultural / language background? ❒ Yes ❒ No_____
Are you afraid of anyone in your home or anyone close to you? ❒ Yes ❒ No Have you recently been slapped, kicked, punched, verbally abused or threatened by anyone close to you? ❒ Yes ❒ No Has someone stopped you from seeking care? ❒ Yes ❒ No
Do you have financial concerns related to this visit? ❒ No ❒ Yes - Referred to Hospital Assistance Coordinator (231) 935-6932.
*All "YES" responses may not be addressed Follow up with your family physician for "YES" responses.

5. ALLERGIES

Medication allergies	What happens when taken?	Medication allergies:	What happens when taken?

OTHER ALLERGIES (e.g. foods, pollens, etc.)
SPECIFIC ALLERGIES: Have you ever had problems with: **LATEX: ❒ YES ❒ NO**
XRAY DYE: ❒ Have not had ❒ No ❒ Yes What type of reaction did you have?

Reviewed by (date/signature)_____
Updates: ❒ No change_____ ❒ No change_____ ❒ No change_____
date / init date / init date / init

Place Patient Label Here

HEALTH HISTORY QUESTIONNAIRE