SHERBAN SPINE INSTITUTE

8190 S. Jog Rd. Ste. 100 Boynton Beach, FL 33472
PHONE: (844) 733-3774

DATE: _____

MEDICAL HISTORY QUESTIONNAIRE: Family Physician: _____ Chiropractor_____
Physical Therapy: _____ Cardiologist: _____

ALLERGIES): _____ _____ _____
_____ _____ _____

MEDICATIONS: Please list your most current medications and who prescribes them

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

SOCIAL HISTORY:

ALCOHOL: DO YOU DRINK? **Y OR N** IF YES, HOW MUCH AND HOW OFTEN: SOCIAL / OCCASIONAL / MODERATE

SMOKING AND CHEWING TOBACCO: DO YOU SMOKE? Y or N < PACK A DAY___1-2 PACKS A DAY___ >3 PACKS A DAY___

CHEWING TOBACCO____ PREVIOUS SMOKER: Y or N WHEN DID YOU QUIT? _____

Surgical History & The Date Performed: _____ _____ _____
_____ _____ _____

PRESENT MEDICAL CONDITIONS: Please check any medical conditions you are being treated for or have been in the past
NO MEDICAL PROBLEMS REPORTED ☐

MEDICAL PROBLEMS	YOURSELF	FAMILY MEMBER	MEDICAL PROBLEMS	YOURSELF	FAMILY MEMBER
Asthma			Dialysis or Kidney Failure		
Emphysema			Urinary tract infections		
COPD			Diabetes		
Pneumonia			Thyroid problems		
Tuberculosis			Osteomyolitis		
Pulmonary Embolism			Bleeding disorders		
Respiratory Arrest			Anesthesia problem / Malignant hyperthermia		
Sleep Apnea			Peripheral Vascular Disease (PVD)		
High Cholesterol/Lipids			Deep Vein Thrombosis (DVT)		
High Blood Pressure			Cerebral Palsy		
Stroke / TIA			Polio		
Mitral Valve Prolapse			Parkinson's		
Congestive Heart Failure			Multiple Sclerosis		
Angina (Chest Pain)			Ulcers skin/pressure		
Coronary Heart Disease			Psoriasis		
Heart Attack (Myocardial Infarction)			Tooth abscess		
Arrhythmia (Irregular heart beat)			Gingivitis		
Inflammatory Bowel (Diverticulitis/losis)			Rheumatoid Arthritis		
Acid Reflux (GERD)			Gout		
Gastric / Stomach Ulcer			Lupus		
GI Bleed			Scleroderma		
Hepatitis or liver disease			Depression		
Kidney problems			HIV/AIDS		
Drug OR Alcohol dependency			CANCER		

AUTHORIZATION AND RELEASE:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. **Signature:**_____ **Date:**_____