SAN ANTONIO SPINE CENTER
KEVIN RICHARDSON, D.O.

MEDICAL HISTORY

Patient Name: ______________________________ Date: ______________

Past Surgical History:

Check previous spinal surgeries and when they happened: ☐ None

☐ Cervical ____________ ☐ Thoracic____________ ☐ Lumbar____________

Check all other surgeries: ☐ None ☐ Appendectomy ☐ Cardiac ☐ Tonsillectomy ☐ Thyroid

☐ Wisdom teeth removal ☐ Gallbladder ☐ Other Orthopaedic Surgery ______________

☐ Hernia Repair ☐ Breast ☐ Other ______________________________

Past Medical History (check all that apply):

Musculoskeletal/Joints: ☐ Muscular Disease ☐ Arthritis

Neurological: ☐ Headaches ☐ Migraines ☐ Seizures/Epilepsy ☐ Strokes/TIA

Metabolic: ☐ Diabetes ☐ Thyroid Problems

Bleeding Disorders: ☐ Anemia ☐ Blood Clots ☐ Bleeding Problems

Urinary: ☐ Blood in Urine ☐ Frequent Urination ☐ Trouble starting urination
☐ Trouble stopping urination ☐ Pain with urination ☐ Prostate Disease

Respiratory: ☐ Asthma ☐ Bronchitis ☐ COPD ☐ Emphysema ☐ Pneumonia ☐ Tuberculosis

Cardiovascular: ☐ HTN ☐ Mitral Valve Prolapse ☐ Aortic Stenosis ☐ Heart Murmur

GI: ☐ Ulcers ☐ Loss of Bowel Control ☐ Diverticulitis/Diverticulosis

Cancer: ☐ Lung ☐ Breast ☐ Colon/Intestinal ☐ Stomach ☐ Prostate
☐ Skin ☐ Bone ☐ Kidney

Others: ☐ Other Malignancy ______________ ☐ Kindey Disease
☐ Liver Disease ☐ Hepatitis

Immunological Diseases: ☐ HIV/AIDS ☐ Rheumatoid ☐ Lupus

Women Only: ☐ EndometrosisAre you on birth control? ☐ No ☐ Yes
Are you pregnant? ☐ No ☐ Yes Due Date:__________

How long ago was your last complete physical? ______________

Do you smoke NOW? ☐ No ☐ Yes Packs per day: __________ for __________ years

Did you smoke in the past? ☐ No ☐ Yes Quit day: __________ for __________ years

Do you drink alcoholic beverages ☐ No ☐ Yes Drinks per week: __________ for __________ years

Do you have a history of alcohol abuse? ☐ No ☐ Yes Please describe: ______________

Allergies: ______________________________

Social History:

Patient's Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Number of children __________ Hobbies: ______________________________

Spouse or significant other's occupation: ______________________________

Family History (check all problems that apply and note the family member):

☐ Diabetes __________ ☐ High Blood Pressure __________ ☐ Heart Disease __________

☐ Vascular Disease __________ ☐ Bleeding Disorders __________

I hereby certify by my signature that the medical information given on this form is correct and complete to the best of my knowledge.

______________________ ______________ ______________________

Patient's Signature Date Verified by Physician/Nurse

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