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ARIZONA SPINE & JOINT HOSPITAL
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Family History Assessment

DIRECTIONS: Form can be completed online or printed and filled in by hand. Once completed, print the form and bring completed forms with you for your Pre-admission visit

	Children	Mother	Father	Brother	Sister
Asthma	☐	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐	☐
Diabetes, Type 1	☐	☐	☐	☐	☐
Diabetes, Type 2	☐	☐	☐	☐	☐
Coronary Artery Disease	☐	☐	☐	☐	☐
Myocardial Infarction	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐
Blood Clots	☐	☐	☐	☐	☐
Hyperlipidemia	☐	☐	☐	☐	☐
Alzheimer's Disease / Dementia	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Anesthesia Problems	☐	☐	☐	☐	☐
Malignant Hyperthermia	☐	☐	☐	☐	☐

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Past Medical History

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				Comments
Respiratory				
	Respiratory Disorders	◯ Yes	◯ No	
	Chronic Obstructive Pulmonary Disease	◯ Yes	◯ No	
	Asthma	◯ Yes	◯ No	
	Chronic Bronchitis	◯ Yes	◯ No	
	Pulmonary Fibrosis	◯ Yes	◯ No	
	Coccidioidomycosis	◯ Yes	◯ No	
	Lung Cancer	◯ Yes	◯ No	
	Pulmonary Embolism	◯ Yes	◯ No	
	Tuberculosis	◯ Yes	◯ No	
	Oxygen Administration	◯ Yes	◯ No	
	BiPAP Dependent	◯ Yes	◯ No	
	CPAP Dependent	◯ Yes	◯ No	
	Sleep Apnea	◯ Yes	◯ No	
	Dyspnea	◯ Yes	◯ No	
HEENT				
	HEENT Problems	◯ Yes	◯ No	

	Blind	Yes	No	
	Glaucoma	Yes	No	
	Macular Degeneration	Yes	No	
	Contacts or Glasses	Yes	No	
	Hearing Aid	Yes	No	
	Hearing Loss	Yes	No	
	Dentures or Partial	Yes	No	
	Temporomandibular Joint Disease	Yes	No	
Endocrine				
	Endocrine Disorders	Yes	No	
	Insulin Dependent Diabetes	Yes	No	
	Non-Insulin Dependent Diabetes	Yes	No	
	Diet Controlled Diabetes	Yes	No	
	Hyperthyroidism	Yes	No	
	Hypothyroidism	Yes	No	
	Hormone Disorder	Yes	No	
Gastrointestinal				
	Gastrointestinal Disorders	Yes	No	
	Gastrointestinal Cancer	Yes	No	
	Gastroesophageal Reflux Disease	Yes	No	
	Colitis	Yes	No	
	Diverticulitis	Yes	No	
	Ulcer	Yes	No	
	Liver Disorder	Yes	No	
	Hepatitis	Yes	No	
	Pancreatic Disorders	Yes	No	
	Celiac Disease	Yes	No	
	Gall Bladder Disease	Yes	No	

	Irritable Bowel	◯ Yes	◯ No	
	Crohn's Disease	◯ Yes	◯ No	
	Hiatel Hernia	◯ Yes	◯ No	
Genitourinary				
	Genitourinary Disorders	◯ Yes	◯ No	
	Renal Insufficiency	◯ Yes	◯ No	
	Renal Failure	◯ Yes	◯ No	
	Kidney Cancer	◯ Yes	◯ No	
	Kidney Stones	◯ Yes	◯ No	
	Bladder Cancer	◯ Yes	◯ No	
	Neurogenic Bladder	◯ Yes	◯ No	
	Urinary Tract Infection	◯ Yes	◯ No	
	Benign Prostatic Hyperplasia	◯ Yes	◯ No	
	Prostate Problems	◯ Yes	◯ No	
	Incontinence	◯ Yes	◯ No	
	Urination Urgency	◯ Yes	◯ No	
	Urinary Self Catheterization	◯ Yes	◯ No	
Reproductive				
	Reproductive Disorders	◯ Yes	◯ No	
	Breast Cancer	◯ Yes	◯ No	
	Last Menstrual Period	Date		
	Pregnant Now	◯ Yes	◯ No	
	Breastfeeding Now	◯ Yes	◯ No	
Cardio				
	Cardiac Disorders	◯ Yes	◯ No	
	Heart Attack	◯ Yes	◯ No	
	Angina	◯ Yes	◯ No	
	Heart Murmur	◯ Yes	◯ No	

	Congestive Heart Failure	◯ Yes	◯ No	
	Mitral Valve Prolapse	◯ Yes	◯ No	
	Abdominal Aortic Aneurysm	◯ Yes	◯ No	
	Peripheral Vascular Disease	◯ Yes	◯ No	
	Embolitic Filter	◯ Yes	◯ No	
	Irregular Heartbeat	◯ Yes	◯ No	
	Atrial Fibrillation	◯ Yes	◯ No	
	Hypertension	◯ Yes	◯ No	
	Hypotension	◯ Yes	◯ No	
	Deep Vein Thrombosis	◯ Yes	◯ No	
	Hyperlipidemia	◯ Yes	◯ No	
	Hypercholesterolemia	◯ Yes	◯ No	
Neurological				
	Neurological Problems	◯ Yes	◯ No	
	Neurological Aneurysm	◯ Yes	◯ No	
	Cerebrovascular Accident	◯ Yes	◯ No	
	Transient Ischemic Attacks (TIA)	◯ Yes	◯ No	
	Cerebral Hemorrhage	◯ Yes	◯ No	
	Alzheimer Dementia	◯ Yes	◯ No	
	Parkinson’s Disease	◯ Yes	◯ No	
	Seizures	◯ Yes	◯ No	
	Neuromuscular Disorder	◯ Yes	◯ No	
	Multiple Sclerosis	◯ Yes	◯ No	
	Paralysis	◯ Yes	◯ No	
	Peripheral Neuropathy	◯ Yes	◯ No	
	Memory Loss	◯ Yes	◯ No	
	Dizziness	◯ Yes	◯ No	
	Syncope	◯ Yes	◯ No	

	Headaches	Yes	No	
	Migraine	Yes	No	
Musculoskeletal				
	Fibromyalgia	Yes	No	
	Arthritis	Yes	No	
	Degenerative Disk Disease	Yes	No	
	Herniated Disk	Yes	No	
	Spinal Stenosis	Yes	No	
	Gout	Yes	No	
	Back Problems	Yes	No	
Other				
	Cancer	Yes	No	
	Sjogren's Syndrome	Yes	No	
	Infectious Diseases	Yes	No	
	Have you traveled outside the US within the past 21 – 30 days?	Yes	No	
	Have you been in contact with anyone that has travelled?	Yes	No	
	Are you experiencing any symptoms of illness at this time?	Yes	No	
	Blood Disorders	Yes	No	
	Immunizations Up To Date	Yes	No	
	Influenza Vaccination	Yes	No	
	Pneumonia Vaccination	Yes	No	
	Metal Implant / Fragment	Yes	No	
	Implanted Device	Yes	No	
	Body Piercing	Yes	No	
	Non Healing Wound	Yes	No	
	Have you had MRSA, VRE or C Diff?	Yes	No	
	Recent Acute Infection	Yes	No	

	Recurrent Infection	◯ Yes	◯ No		
	Miscellaneous Medical Problems	◯ Yes	◯ No		
Psychosocial					
	Psychiatric Conditions	◯ Yes	◯ No		
	Psychiatric / Substance Use Disord	◯ Yes	◯ No		
	Social Services Referral	◯ Yes	◯ No		
	Depression	◯ Yes	◯ No		
	Anxiety	◯ Yes	◯ No		
	Alcohol Use	◯ Yes	◯ No		
	Substance Use	◯ Yes	◯ No		
	Smoking Status	◯ Current every day smoker ◯ Current some day smoker ◯ Former smoker ◯ Never smoked		◯ Smoker, status unknown ◯ Unknown if ever smoked ◯ Heavy tobacco smoker ◯ Light tobacco smoker	
	Have you smoked in the past 12 months?	◯ Yes	◯ No		
	Smoking Start Date				
	Smoking Stop Date				
	Chewing Tobacco Use	◯ Yes	◯ No		
	Cigarettes, Pipes, Cigars or cans of Tobacco				
	Years Tobacco Use				
	Tobacco Use Comment				

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1. Please list all medications including over-the-counter drugs, vitamins and supplements. (collect your prescription bottles and take the information off of the labels)

MEDICATION NAME	DOSAGE	HOW OFTEN DO YOU TAKE IT

Please indicate your preferred pharmacy.

Name	
Address	
Phone	

2. Please list any medication/food allergies and what reaction you have. Please include any latex, iodine or adhesive allergies.

ALLERGY	REACTION

3. Please list all prior surgeries:

4. Have you had any reactions to Anesthesia in the past? YES ☐ NO ☐
   If Yes please describe the reaction: _ _____
   _____
   _____

PAIN

Where is your pain located?

☐ None	☐ Upper Extremity	☐ Pelvis
☐ Back	☐ Neck	☐ Other
☐ Head	☐ Lower Extremity	

How long have you had it? _____

How would you describe it?

☐ Aching	☐ Burning	☐ Throbbing
☐ Crushing	☐ Dull	☐ Sharp
☐ Spasm	☐ Shooting	☐ Radiating
☐ Tightness	☐ Acute	☐ Chronic
☐ Comfortable	☐ Sleeping	

What makes the pain worse?

☐ ADL's	☐ Changing Position	☐ Exercise/ Activity
☐ Standing	☐ Sitting	☐ Walking
☐ Stair Climbing		

What helps ease the pain?

☐ Ice	☐ Heat	☐ Medication
☐ Inactivity	☐ Exercise	☐ Position Change
☐ Sitting	☐ Standing	☐ Lying Supine
☐ Lying Prone	☐ Distraction	☐ Elevation