THE AMERICAN CENTER FOR
SPINE & NEUROSURGERY

712 S. Milwaukee Avenue
Libertyville, IL 60048

Past Medical History

Patient Name _____ DOB_____ Date_____

Do you have or have you had:

☐ High Blood Pressure ☐ Diabetes ☐ Stroke ☐ Cancer ☐ Epilepsy/Seizure ☐ Heart Problems

☐ Depression or Psychiatric Disease ☐ Thyroid Problems ☐ None of these

Have you done physical therapy for the issue you are seeing the doctor for? ☐ Yes ☐ No If yes, indicate how many sessions/how long and name of therapist: _____

Past Surgical History

Previous Spine Surgery? ☐ Yes ☐ No If yes, please indicate type and year_____

Other Previous Surgeries (indicate type and year): _____

_____

_____

Allergies

Do you have any allergies? ☐ Yes ☐ No If yes, please describe _____

Medications

List medications you are currently taking

Medication Name	Dose/Frequency
_____	_____
_____	_____
_____	_____
_____	_____

Social History

Do you smoke? ☐ Yes ☐ No If yes, how many cigarettes do you smoke per day?_____

☐ Yes ☐ No If yes, are you interested in quitting?

Do you drink alcohol? ☐ Yes ☐ No If yes, how often? _____ How many drinks? _____

Family History

	Living (Age)	Health Status	Deceased (Age)	Cause of Death
Mother				
Father				

	Number	Age(s)	Serious Illness	Number Deceased	Age at Death
Brother(s)					
Sister(s)					
Child(ren)					

Work History

Occupation: _____ Are you still working? ☐ Yes ☐ No

If no, what is the date you last worked? _____