NEUROSURGICAL SPINE SPECIALISTS™
R. BLAINE RAWSON, M.D.

Date: ___________

History and Physical Form

Name: _______________________________________ Date of Birth: __________________ Age: _____

Gender: Male _____ Female _____ Height: _____ Weight: _____ BP: _____/_____ T: ____ P: ____ R: ____

CURRENT MEDICATIONS:

Name	Dose	Frequency

ALLERGIES:

List allergies (and the type of reaction) to medicines, dyes, food etc.

Allergy to:	Y	N	Reaction
Latex	__	__	______________________
Tape	__	__	______________________
IV Contrast Dye	__	__	______________________

____
____
____
____
____

List any important over-the-counter Medicines, herbs, or other remedies you take regularly:

____
____
____
____
____

Surgical History:

Date:	
________	____
________	____
________	____
________	____
________	____

PAST MEDICAL HISTORY:

	Yes	No
Heart Attack	___	___
Congestive Heart Failure	___	___
Heart Arrhythmia	___	___
Atrial Fibrillation	___	___
Hypertension	___	___
Heart Valve Replacement	___	___
Pacemaker	___	___
Asthma	___	___
Bronchitis	___	___
COPD	___	___
Blood Clots	___	___

	Yes	No
Diabetes:	___	___
Type 1	___	___
Type 2	___	___
Depression	___	___
Anxiety	___	___
Hepatitis	___	___
Cirrhosis of the Liver	___	___
Renal Failure	___	___
Dialysis	___	___
Arthritis	___	___
Cancer: _____________	___	___

Please list any other Medical Conditions not listed:

_________________________ _________________________ _________________________ _________________________
_________________________ _________________________ _________________________ _________________________

SOCIAL HISTORY:

Do you smoke: (Circle one) Yes No Past
How many per day: _____
Every day: ____
Some Days: ____
Years smoking: ____
When did you quit: _____
Use Recreational drugs: (Circle one) Yes No Past
Drink Alcohol: (Circle one) Yes No Past
If yes, what amount: _______________
Currently working: Yes No Retired
Occupation: ______________________
If not retired, last day worked: __________

FAMILY HISTORY:

Do you have immediate family members who have been diagnosed with the following:

	No	Yes	Father	Mother	Sibling	Son	Daughter
Tumor or Cancer	___	___	___	___	___	___	___
Liver Disease	___	___	___	___	___	___	___
Heart Disease	___	___	___	___	___	___	___
Blood Clots	___	___	___	___	___	___	___
Lung Disease	___	___	___	___	___	___	___
Diabetes	___	___	___	___	___	___	___
Hypertension	___	___	___	___	___	___	___
Other: _________	___	___	___	___	___	___	___