Texas Health Neurosurgery and Spine Specialists

Today's Date: ___________

Patient Name: ______________________________________ DOB: ____________________

Preferred Pharmacy: _________________________________ Phone #: ____________________

Drug Allergies: ____

***Please help us to better care for you by telling us what prescription drugs you are taking including any over-the counter medications.**

Medication Name	Dosage, AM or PM & Times per day	Reason for Prescription	Prescribing Provider

Medical History

Have you ever had surgery? If yes, please list the surgery including dates

____

____

____

____

Social History

Tobacco use? Yes/No How much? __________ How often? __________ For How Long? __________

Alcohol use? Yes/No How much? __________ How often? __________ For How Long? __________

Drug use? Yes/No How much? __________ How often? __________ For How Long? __________

What type of work do you do? ____

How long have you been at your present job? __________________________________

Family History

	Age	Living or Deceased?	Health Problem/Cause of Death
Mother			
Father			
Sister (s)			
Brother (s)			