JASON M. GALLINA, M.D., P.C.

ORTHOPEDIC SPINE SURGEON

154 WEST 14TH STREET, 4TH FLOOR
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TEL (212) 616-4130
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HEALTH QUESTIONNAIRE

Patient Name: _____ Telephone _____ Date _____

Reason for visit: _____

SOCIAL HISTORY:

Marital Status: Please circle Single Married Divorced Widowed Other _____
Height_____ Weight _____
Is there anyone at home able to take care of you? ____ Yes ____ No
Have you used any of the following substances?
Tobacco ____ Never ____ Previously, but I quit ____ Currently – Frequency ____
Alcohol ____ Never ____ Rarely ____ Weekly ____ Daily

FAMILY HISTORY: *If any blood relative has suffered any of the following – please circle the number and indicate which relative*

1) Epilepsy	5) Diabetes	9) Anemia	13) Heart Disease	17) Alcoholism
2) Migraine	6) Thyroid	10) Bleeds easily	14) Stroke	18) Hepatitis
3) Mental Illness	7) Hayfever	11) Osteoporosis	15) Hypertension	19) Cancer
4) Glaucoma	8) Asthma	12) Arthritis	16) High Cholesterol	20) Bleeding problems

MEDICATION HISTORY:

List All Medications Your are currently taking – include those you buy without a prescription	Allergies	Vaccine	Year of Last	Test/Exam	Year of Last
_____		Tetanus/Td		Rectal/Stool	
_____		Influenza (flu)		Cholesterol	
_____		Pneumonia		Eye Exam	
_____		Hepatitis		TB Test	
_____				Hepatitis	

HOSPITAL ADMISSIONS:

Year	Illness or Operation	Year	Illness or Operation

SURGICAL HISTORY:

	YES	NO
Have you ever had any surgeries? (Please list on back)	☐	☐
Have you been hospitalized within the last year?	☐	☐
Have there been any changes in your medical condition within the last year?	☐	☐
Have you been treated for a medical condition in the last year?	☐	☐
Have you received any blood transfusions?	☐	☐
Have you ever had an infection in an incision after surgery?	☐	☐
Have you ever had problems with anesthesia?	☐	☐
Have you or a family member ever had a bleeding problem after surgery?	☐	☐

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Health Questionnaire – Continued

ALLERGIES & SENSITIVITIES: Have you experienced any reaction following the administration of any of the following:

	YES	NO	UNSURE
Penicillin or other antibiotics	☐	☐	☐
Morphine, Codeine, Demerol, or other narcotics	☐	☐	☐
Aspirin or other pain medication	☐	☐	☐
Sulfer Drugs	☐	☐	☐
Tetanus Antitoxin or other serums	☐	☐	☐
Adhesive tape or surgical tape	☐	☐	☐
Any foods (i.e. eggs, milk, chocolate, etc.)	☐	☐	☐
Other: _____	☐	☐	☐

MEDICAL HISTORY: *Mark (c) for current problems or (√) and indicate age when you had any of the following symptoms or diseases*

Decreased hearing	Leg pain – *when walking*	Pain on urination	Rashes/Hives	Recent
Ringing in ear(s)	Varicose veins - *Phlebitis*	Blood in urine/kidney stones	Psoriasis/Eczema	Males: Prostate Problems
Ear infections – *frequent*	Cold numb feet	Urinary infections - frequent	Depression/Nervousness	Females: Please complete:
Dizzy/fainting spells	Loss of appetite - *recent*	Sexually transmitted disease	Agitation/Memory Loss	Menstrual flow:
Failing vision/eye pain	Difficulty swallowing	Sexual problems	Any sleeping difficulty	Reg/Irreg/Pain or cramps
Double or blurred vision	Heartburn/peptic ulcer	Weight loss/gain - *recent*	Moodiness/suicidal thoughts	Days of flow
Nose bleeds - *recurrent*	Persistent nausea/vomiting	Anemia/bruise easily	Phobias/mental illnesses	Length of cycle
Sinus trouble	Abdominal pain - *chronic*	Blood transfusions	Feelings of worthlessness	Date of 1st day of last period
Sore throats – *frequent*	Gallbladder trouble	Cancer	Rheumatic fever/scarlet fever	Pain/bleeding during or
Hoarseness - *prolonged*	Jaundice/hepatitis	Chronic Fatigue	Chicken pox/Polio/Mumps	after sex
Hayfever/allergies	Diarrhea/Constipation	Diabetes	Measles/German measles	Number of:
Pneumonia/pleurisy	Diverticulosis/Crohn's/Colitis	Thyroid Disease	Tuberculosis	Pregnancies___
Bronchitis/chronic cough	Inflammatory bowel syndrome	Seizures	Herpes	Miscarriages ___
Asthma/wheezing	Bloody or tarry stools	Stroke	AIDS/HIV	Abortions ____
Shortness of breath:	Hemorrhoids/hernia	Tremors/hands shaking	Alchohol ___oz per wk	Live births ____
on exertion/lying flat	Urination – overactive bladder	Numbness/tingling sensation	Coffee/tea ___ cups per day	Birth control method _____
Chest pain	Overnight more than 2x	Headaches - *frequent*	Smoking ___ cig/day __yrs	BC Pill name_____
High blood pressure	More than 8 x/24 hrs	Arthritis/Rheumatism	Exercise	Flushing/menopause
Heart murmur	Urgency to urinate/leakage	Back pain – *recurrent*	Street drugs	Date of last Pap test
Swollen ankles	Decrease in force/flow	Bone fracture/joint injury	Acupuncture/tattoos	Normal/Abnormal
Irregular pulse	Stress incontinence – urine	Osteoporosis	Hair loss	Date of last mammorgram
Palpitations	leakage on exercise/movmnt	Foot pain - Gout	Progressive	Normal/Abnormal

If you answered yes to any of the above questions on either page, please explain in detail, use the back of the page if necessary.

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