PATIENT HEATH QUESTIONNAIRE

Back Pain
Neck Pain
Extremity Pain (specify)
____
Aortic Aneurysm
Chest Pain/Heart Attack
Osteoporosis
Headache
Dizziness/Loss of Balance
Cancer (specify) ________________

Diabetes
Rheumatoid Arthritis
Pregnancy
Weight Loss/Weight Gain
Bladder/Bowel Function
HIV/AIDS
Stroke
Asthma/Short of Breath
High Blood Pressure: _________
Height: _______Weight: ________

Have you fallen in the last 2 years? Yes No   With injury? Yes No

Do you have a Pacemaker? _______ Do you have a Spinal Implant? _______

Please list medications: ____
____

Please list prior surgeries: ____

Spine & Sport Institute believes that knowledge is power in your healthcare. We may periodically e-mail you information regarding the following topics of interest to you. Please circle any topics of interest to you:

*Balance
*Fatigue
*Sleep

*Cancer risk
*Diabetes
*Stress
*Osteoporosis

*Overall Fitness
*Endurance
*Obesity/BMI

*Muscle Strength
*Optimal Nutrition

Do you have a permanent Disability rating? Location __________ Date ___/___/___ Rating % ____

Patient Signature ___________________________________ Date ___________

REV. 04/2020