SPORTS AND ORTHOPEDIC SPECIALISTS

HEALTH QUESTIONNAIRE

Please fill out the following questionnaire before the first visit and bring it with the rest of your patient packet.

_____
PATIENT NAME

_____
DATE

Please check the box if you have a current or past history of any of the following conditions:

- ☐ Allergies: _____
- ☐ Auto-immune disease: _____
- ☐ Back or Neck Pain: _____
- ☐ Balance Problems/Vertigo
- ☐ Cardiovascular Disease: _____
- ☐ Cognitive Impairment
- ☐ Depression, Anxiety or Panic Disorders
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia
- ☐ Headaches
- ☐ Hearing Impairment
- ☐ Hepatitis
- ☐ Hernia
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ History of Cancer
- ☐ Kidney, Bladder or Prostate Problems
- ☐ Lupus
- ☐ Multiple sclerosis
- ☐ Neuropathy
- ☐ Osteoarthritis: _____
- ☐ Osteoporosis/Osteopenia
- ☐ Parkinson's disease
- ☐ Rheumatoid arthritis
- ☐ Sleep Dysfunction
- ☐ Traumatic Brain Injury
- ☐ Thyroid condition
- ☐ Ulcers
- ☐ Urination Problems/ Incontinence
- ☐ Visual Impairment

Other: _____
_____
_____
_____

Prior surgery: _____
_____
_____
_____

Health Questions:

- Do you smoke? Yes ☐ No ☐
- Do you drink alcohol? Yes ☐ No ☐
- How would you describe your health in general?
  ☐ Excellent ☐ Good ☐ Fair ☐ Poor
- Are you currently pregnant or think you might be pregnant? Yes ☐ No ☐
- Have you had one or more falls in the past year? Yes ☐ No ☐
- Have you had any fall with an associated injury in the past year? Yes ☐ No ☐

List any medications that you are taking:
_____
_____
_____
_____

What are your current sports activities and/or exercise program? _____
_____

Please list any condition for which you are being treated that has not been noted above:
_____
_____
_____
_____

PT INITIAL _____