**Spine & Sport: Patient Medical History and Health Risk Profile**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: Height: Weight: \_\_Gender: \_\_\_Male Female\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT:

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Problems to be treated today:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had treatment for this problem before: ( ) YES ( ) NO When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the type of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had surgery associated with this problem? ( ) YES ( ) NO

If so, please list date(s) and type(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any other condition that is aggravated by exercise? ( ) YES ( ) NO

If so, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please list the names of any primary care physican/internist/cardiologist that you are seeing, or have seen in the past:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you currently pregnant? ( ) YES ( ) NO
2. Do you need assistance with any of the following?
   1. Transportation YES NO d. Meals YES NO
   2. Shopping/Errands YES NO e. Personal care YES NO
   3. Domestic chores YES NO f. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Has your illness/disability caused any of the following?
   1. Financial Problems YES NO c. Family Problems YES NO
   2. Emotional Problems YES NO d. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Do you have or have you had any of the following?

Feel faint or dizzy YES NO Osteoporosis YES NO

Frequent pain in heart/chest YES NO Known Heart disease YES NO

Pacemaker YES NO Diabetes YES NO

Headaches YES NO Swollen ankles YES NO

Nervous Disorders YES NO Kidney problems YES NO

Allergies YES NO Heat sensitivity YES NO

Seizures YES NO Hernia YES NO

Balance problems YES NO Metal Implants YES NO

Hearing problems YES NO Vision Problems YES NO

High Cholesterol YES NO High Blood Pressure YES NO

Cancer YES NO Low Blood Pressure YES NO

Tuberculosis YES NO

1. Please circle the closest answer or leave item blank if you do not know:

Cigarettes (per day) NEVER 1-5 10-20 30-40 >50

Alcoholic drinks (per week) NEVER 1-5 10-20 >20

Cardiovascular Fitness (per week) NONE Occasional/ 3+ days/week for at least

Recreational 15 minutes per day

1. Respiratory Status: NORMAL MODERATE SEVERE (shortness of breath with mild exertion)

For office use only: I have read the Health Risk Profile and the following is appropriate:

* Contact MD with CV Screening Reqest Form or request results of exercise test within last 2 years;
* Further cardiovascular screening is not necessary at this time.

Clinician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_