Sobel Spine and Sports
Medical Questionnaire

Name: Age: DOB: DOS:
Referral: Handedness: Right / Left

What problem is Dr. Sobel seeing you for today? _____
Where is your pain located? _____
When did it start? _____
How did it start? _____
What makes the pain worse? Sitting Standing Walking Lying down Bending Lifting Not using Other
What makes it better? Sitting Standing Walking Lying down Bending Lifting Not using Other
Is this related to a car accident or a work related injury Yes No _____
What diagnostic tests have you had for this problem? **X-Ray MRI CT Scan EMG Other**
What treatments have you had? **Physical therapy Chiropractic Injections Massage Other**
How would you describe your pain? **Dull Aching Burning Stabbing Numbness Tingling Cramping Tightness**
Is your pain: **Constant or Intermittent Worsening or Improving or Staying about the same**
If there is numbness where is it located? _____
Have you experienced weakness? Yes No _____
What part of the day is your pain at its worst? _____
Have you had surgery for your problem? _____

Exercise frequency: Daily 3-5 times/week 1-2 times per week Rarely
Smoking history Current Quit Never
If you smoked in the past when did you quit? _____
If you smoke now, how many packs/day? _____ How many years? _____
How many alcoholic drinks do you have per week? _____ Do you use marijuana? Yes No
What is your occupation _____
Have you ever had a problem with substance abuse or addiction? Yes No

Notes: (MA use only) _____
_____
HPI: (for office use only) _____
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Past Medical History (please circle all that are apply)

AIDS/HIV
Anemia
Rheumatoid arthritis
Asthma
Atrial fibrillation
Enlarged prostate
Cancer
Diabetes
Heart stents/bypass
Emphysema
Crohn's disease
Lupus
Depression/Anxiety
Blood clot
Fibromyalgia
Osteoarthritis
Gallbladder disease
Hearing loss
Heartburn
Gout
Liver disease
Hepatitis
High cholesterol
High blood pressure
Low blood pressure
Ulcerative colitis
Kidney disease
Headaches
Migraines
Multiple Sclerosis
Osteoporosis
Spinal fracture
Parkinson's disease
Psoriasis
Scoliosis
Bleeding disorder
Vascular disease
Low back pain
Neck pain
Seizures
Peripheral neuropathy
Sleep apnea
Spinal stenosis
Low thyroid
Heart valve disease
Glaucoma/eye disorder
Joint replacement
Stroke
Carpal tunnel syndrome
Joint pain
Pacemaker
Gastric bypass
Recent infection
Autoimmune disorder
Shingles
Seasonal allergies
Other _____
Other _____
Other _____
Other _____

Past Surgical History (please list the surgeries you have had)

1. _____
2. _____
3. _____
4. _____
5. _____

Review of Systems (please circle all that apply)

Constitutional
Chills
Fever
Fatigue
Night sweats
Weight loss

Allergy/Immunologic
Congestion
Watery eyes
HIV positive
Rash
Seasonal allergies

HEENT
Blurry vision
Eye pain
Dry eye
Hearing loss
Ringing in ear
Swollen glands

Cardiovascular
Chest pain
Palpitations
Fluid in legs
Chest pain

Respiratory
Asthma
Shortness of breath
Wheezing
Cough up blood
Chest pain
Breathing difficulty

Gastrointestinal
Abdominal pain
Black stools
Blood in stools
Heartburn
Difficulty swallowing

Genitourinary
Blood in urine
Difficulty urinating
Frequent urination
Painful urination

Musculoskeletal
Joint stiffness
Joint pain
Swollen joints
Leg cramps

Neurological
Numbness
Weakness

Hematology/Vascular
Blood clots in legs
Bleeding problems
Anemia

Endocrine
Cold intolerance
Heat intolerance
Dizziness
Hot flashes
Weakness
Excessive thirst

Psychiatric
Anxiety
Depressed mood
Difficulty sleeping
Loss of appetite
Psychiatric condition

How many times have you fallen in the past 12 months? None 1 2+ with/without injury

Family History (please circle all that apply)

Father:	Living/Deceased	Cancer	Heart disease	Stroke	Diabetes	Hypertension
Mother:	Living/Deceased	Cancer	Heart disease	Stroke	Diabetes	Hypertension

Current Medications:

Medication	Dose	Frequency

List any known drug allergies: _____

For office use only:

Height: Weight:

BP: Pulse: