The Spine & Sports Center
Ed Benny, MD

RETURN PATIENT QUESTIONNAIRE

Today's Date:

Name:_____ Date of Birth:_____ Age:_____ Sex: _____

Primary Physician's Name & Address	Referring Physician's Name & Address

Preferred Pharmacy:_____Phone#:_____

PAST MEDICAL HISTORY

HISTORY OF:

HYPERTENSION:_____

DIABETES:_____

HEART DISEASE:_____

STROKE:_____

SEIZURES:_____

MENINGITIS:_____

MIGRAINES:_____

PAST SURGICAL HISTORY

HEAD:_____

SPINE:_____

FAMILY HISTORY

MIGRAINE:_____

SEIZURES:_____

STROKE:_____

MEDICATIONS AND ALLERGIES

Drug Name	Dose	How Often	For Pain Meds Only - - Does it help?
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know

LIST ALL KNOWN ALLERGIES:

_____

_____

SOCIAL HISTORY

Do you drink alcohol?_____
How much alcohol do you usually drink per week? _____
Have you been a cigarette smoker in the past 5 years?_____
Currently, do you smoke? If yes, how much per day _____

OB/GYN HISTORY (FEMALES ONLY)

LAST MENSTRUAL PERIOD:_____

CURRENTLY USING CONTRACEPTION:_____ TYPE:_____

CURRENTLY PREGNANT:_____ POSSIBILITY OF PREGNANCY:_____