ALIGN SPINE HEALTH CENTER, LLC

PATIENT QUESTIONNAIRE:

Today's Date: _____

PATIENT NAME: _____ ***DATE OF BIRTH:*** _____/_____/_____

I. PLEASE LIST ALL CURRENT MEDICATIONS:

A. _____ D. _____
B. _____ E. _____
C. _____ F. _____

II. PLEASE LIST ANY ALLERGIES TO MEDICATIONS AND ALLERGIC REACTION TYPE:

Medication Allergy	Type of Reaction (i.e. hives)	Onset Date of Reaction
• _____	_____	____/_____/_____
• _____	_____	____/_____/_____
• _____	_____	____/_____/_____
• _____	_____	____/_____/_____

III. PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR DEMOGRAPHICS:

PLEASE PLACE AN "X" NEXT TO YOUR RESPONSE

- **ETHNICITY:** ____ Non-Hispanic or Latino ____ Hispanic or Latino
- **RACE:**
  ____ White
  ____ Black/African American
  ____ Unknown/Not Reported
  ____ American Indian/Alaska Native
  ____ Native Hawaiian/Pacific Islander
  ____ Asian
- **PREFERRED LANGUAGE:**
  ____ English ____ Italian ____ Japanese
  ____ Spanish ____ Russian ____ Korean
  ____ French ____ Portuguese ____ Vietnamese
  ____ German ____ Chinese ____ Other _____

IV. SMOKING STATUS: ***PLEASE PLACE AN "X" NEXT TO YOUR RESPONSE***

____ CURRENT EVERY DAY SMOKER
____ CURRENTSOME DAY SMOKER
____ FORMER SMOKER
____ NEVER SMOKED
____ SMOKER CURRENT STATUS UNKNOWN
____ UNKNOWN IF EVER SMOKED

V. EMAIL ADDRESS: Provide your email address for distribution of health records and correspondence

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