Patient History Questionnaire

Patient Name Age Date of Birth (Month/day/year)	
Occupation/Student Currently working? Since more	nth/day/year
ARE YOU AN ATHLETE? If YES, Which SPORT(s)	
High School Professional	
<u>ft in lbs</u> (circle one)	
	ht Handed
CHIEF COMPLAINT (Explain why you are here, include symptoms, body part, etc.)	
IS THIS AN INJURY? If yes, DATE OCCURRED WORK RELA ATTORNEY? YES NO NAME of Attorney: IS THIS A CHRONIC PROBLEM? YES NO HOW LONG? DESCRIBE IN DETAIL WHAT HAPPENED:	
HOW DID THE CONDITION BEGIN?	
SuddenlyPulling Work Injury	
Lifting Fall Sports Injury	
Auto Accident	
DOES INJURY OR COMPLAINT PREVENT YOU FROM WALKING? (Circle one) YES NO	
If YES, how far can you walk without stopping?	
DESCRIBE YOUR PAIN/LOCATION:	
WHEN ARE YOU AFFECTED (PLEASE CIRCLE) Morning Day Nigh	ht
0 1 2 3 4 5 6 7 8 9 10 No Moderate Worst pain pain possible pain	
WHAT MAKES IT BETTER?WHAT MAKES IT WORSE?	
HAS THIS EVER BEEN INJURED BEFORE? YES / NO If YES, who treated you?	
HAVE YOU HAD SURGERY TO THIS AREA? YES / NO If YES, when and name of surgeon?	
HAVE YOU HAD: WHEN, WHEN and LIST TYPE: X-RAYS MRI	
CAT SCAN	
ULTRASOUND	DID THIS HELP?
PHYSICAL THERAPY OCCUPATIONAL THERAPY	YES / NO YES / NO
MEDICATIONS	YES / NO YES / NO
BRACES ORTHOTICS or SPECIAL SHOES	YES / NO YES / NO

Mother Father Other Mother Father Other Mother Mot	ape	WHAT ALLERGIC TO: Latex VY HISTORY OF: Mother Father Other Father Other	MEDICATIONS DO YOU TA PLI	EASE DESCRIBE YOUR REACTION:
ARE YOU ALLERGIC TO: PLEASE DESCRIBE YOUR REACTION:	ape	ALLERGIC TO: Latex V HISTORY OF: Mother Father Other Father Other	PLI]Other	EASE DESCRIBE YOUR REACTION:
Fape	ape	□Latex □ LY HISTORY OF: Other Mother Father Other Father Other	Other	
Date	ape	□Latex □ LY HISTORY OF: Other Mother Father Other Father Other	Other	
Diabetes Mother Father Other Diabetes Diabetes Mother Father Other Diabetes Diabet	eart Disease iabetes Mother ther Illness ou Smoke?	LY HISTORY OF: Mother□ Father□ Other Father□ Other		
Heart Disease Mother Father Other	eart Disease iabetes Mother ther Illness ou Smoke? Yes [Have you Quit? Yeou drink Alcohol?	Mother□ Father□ Other Father□ Other		
Diabetes Mother Father Other	iabetes Mother ther Illness ou Smoke?	Father Other		
Diabetes Mother Father Other	iabetes Mother ther Illness ou Smoke?	Father Other		
Other Illness	ou Smoke?			
Have you Quit? Yes No Cigarettes Cigar Pipe How many per day?	Have you Quit? □Y		Mother Father	
Have you Quit? Yes No How long?	Have you Quit? □Y		Mother Father	Other
you drink Alcoho!? Yes No How Often? you use OTC/Herbal Supplements? Yes No Type/Frequency you use illegal substances? Yes No Type/Frequency REVIEW OF SYSTEMS: (PLEASE CHECK ANY HEALTH PROBLEMS IN THE FOLLOWING AREAS) HEART MUSCULOSKELETAL RESPIRATORY ENDOCRINE Thyroid Disease Osteoporosis Emphysema Diabetes Type T	ou drink Alcohol?	No □Cigarettes □Cigar [☐Pipe How many per day?	# of Years
you use OTC/Herbal Supplements?		es No Howlong?		
you use OTC/Herbal Supplements?		_		
you use illegal substances?	ou use OTC/Herhal S			
REVIEW OF SYSTEMS: (PLEASE CHECK ANY HEALTH PROBLEMS IN THE FOLLOWING AREAS) HEART				
Coronary Artery	REVIEW	· -		
Chronic Muscle Pain	HEART	MUSCULOSKELETAL	RESPIRATORY	ENDOCRINE
Hypertension □Chronic Muscle Pain □Sleep Apnea □Excessive Weight Loss □High Cholesterol □Swollen Joints □Shortness of Breath □Excessive Weight Gain □Heart Mumur □Other □Other □Other □Other □Other □Other □Other □Numbness □Phlebitis □Blurry Vision □Frequent □Burning □Seizure Disorder □Clotting/Bleeding Problems □Hearing Loss □Blood in Urine □Tremors □Stroke □Easy Bruising □Ring in Ears □Kidney Stone □Other □Other □Other SKIN GASTROINESTINAL PSYCHIATRIC GENERAL □Rash □Psoriasis □Reflux □Peptic Ulcer □Anxiety □Depression □Cancer □Cancer □ □Lesions □Moles □Hepatitis □Gallstones □Schizophrenia □ADHD □Fever □Chills □Other □Other □Other □Other □Other □OTHER	☐Coronary Artery	☐ Osteoarthritis	□Asthma	☐Thyroid Disease
High Cholesterol □Swollen Joints □Shortness of Breath □Excessive Weight Gain □Other □Other □Other NEURO VASCULAR HEENT URINARY □Numbness □Phlebitis □Blurry Vision □Frequent □Burning □Seizure Disorder □Clotting/Bleeding Problems □Hearing Loss □Blood in Urine □Tremors □Stroke □Easy Bruising □Ring in Ears □Kidney Stone □Other □Other □Other SKIN GASTROINESTINAL PSYCHIATRIC GENERAL □Rash □Psoriasis □Reflux □Peptic Ulcer □Anxiety □Depression □Cancer □Cancer □Chills □Other □Other □Other □Night Sweats □HIV □Other □Other □OTHER	se	□ Osteoporosis	□ Emphysema	□Diabetes Type I Type II
□ Heart Mumur □ Other □ Other □ Other NEURO VASCULAR HEENT URINARY □ Numbness □ Phlebitis □ Blurry Vision □ Frequent □ Burning □ Seizure Disorder □ Clotting/Bleeding Problems □ Hearing Loss □ Blood in Urine □ Tremors □ Stroke □ Easy Bruising □ Ring in Ears □ Kidney Stone □ Other □ Other □ Other SKIN GASTROINESTINAL PSYCHIATRIC GENERAL □ Rash □ Psoriasis □ Reflux □ Peptic Ulcer □ Anxiety □ Depression □ Cancer □ Cancer □ Other □ Other □ Other □ Night Sweats □ HIV □ Other □ Other □ Other □ Other □ OTHER	Hypertension	☐Chronic Muscle Pain	☐Sleep Apnea	☐Excessive Weight Loss
NEURO VASCULAR HEENT URINARY Numbness	☐High Cholesterol	☐Swollen Joints	☐Shortness of Breath	☐Excessive Weight Gain
NEURO VASCULAR HEENT	☐Heart Mumur	□Other	Other	□Other
Numbness □Phlebitis □Blurry Vision □Frequent □Burning □Seizure Disorder □Clotting/Bleeding Problems □Hearing Loss □Blood in Urine □Tremors □Stroke □Easy Bruising □Ring in Ears □Kidney Stone □Other □Other □Other SKIN GASTROINESTINAL PSYCHIATRIC GENERAL □Rash □Psoriasis □Reflux □Peptic Ulcer □Anxiety □Depression □Cancer □ □Lesions □Moles □Hepatitis □Gallstones □Schizophrenia □ADHD □Fever □Chills □Other □Other □Other □Other □Night Sweats □HIV GENITALS/BREAST □Senital □ADHD □OTHER	Other			
□ Seizure Disorder □ Clotting/Bleeding Problems □ Hearing Loss □ Blood in Urine □ Tremors □ Stroke □ Easy Bruising □ Ring in Ears □ Kidney Stone □ Other □ Pain with Swallowing □ Other SKIN GASTROINESTINAL PSYCHIATRIC GENERAL □ Rash □ Psoriasis □ Reflux □ Peptic Ulcer □ Anxiety □ Depression □ Cancer □ Cancer □ Chills □ Lesions □ Moles □ Hepatitis □ Gallstones □ Other □ Other □ Night Sweats □ HIV □ Other □ OTHER □ OTHER □ OTHER □ OTHER	NEURO	VASCULAR	HEENT	
□ Tremors □ Stroke □ Easy Bruising □ Ring in Ears □ Kidney Stone □ Other □ Pain with Swallowing □ Other SKIN GASTROINESTINAL PSYCHIATRIC GENERAL □ Rash □ Psoriasis □ Reflux □ Peptic Ulcer □ Anxiety □ Depression □ Cancer □ Cancer □ Chills □ Lesions □ Moles □ Hepatitis □ Gallstones □ Schizophrenia □ ADHD □ Fever □ Chills □ Other □ Other □ Other □ Night Sweats □ HIV □ OTHER □ OTHER	Numbness	☐Phlebitis	☐Blurry Vision	
□Other □Pain with Swallowing □Other SKIN GASTROINESTINAL PSYCHIATRIC GENERAL □Rash □Psoriasis □Reflux □Peptic Ulcer □Anxiety □Depression □Cancer □Chills □Lesions □Moles □Hepatitis □Gallstones □Schizophrenia □ADHD □Fever □Chills □Other □Other □Other □Night Sweats □HIV □OTHER □OTHER	☐Seizure Disorder	☐Clotting/Bleeding Problems	☐Hearing Loss	☐Blood in Urine
SKIN GASTROINESTINAL PSYCHIATRIC GENERAL Rash Psoriasis Reflux Peptic Ulcer Anxiety Depression Cancer Lesions Moles Gallstones Schizophrenia ADHD Fever Chills Other Other OTHER GENITALS/BREAST	☐Tremors ☐Stroke		_	☐Kidney Stone
SKIN GASTROINESTINAL PSYCHIATRIC GENERAL Rash Psoriasis Reflux Peptic Ulcer Anxiety Depression Lesions Moles Hepatitis Gallstones Schizophrenia ADHD Other Other GENITALS/BREAST	□Other	Other		Other
□Rash □Psoriasis □Reflux □Peptic Ulcer □Anxiety □Depression □Cancer □Lesions □Moles □Hepatitis □Gallstones □Schizophrenia □ADHD □Fever □Chills □Other □Other □Other □OTHER GENITALS/BREAST				
□ Lesions □ Moles □ Hepatitis □ Gallstones □ Schizophrenia □ ADHD □ Fever □ Chills □ Other □ Other □ Other □ Night Sweats □ HIV □ OTHER □ OTHER				
☐ Other ☐ Other ☐ Other ☐ Night Sweats ☐ HIV ☐ OTHER		_	-	
GENITALS/BREAST		_	_	
GENITALS/BREAST	_ Other	Other	∐Other	
				OTHER
Tumor □ Erectile Dysfunction □ Large Prostate □ Nipple Discharge □ Menopause □ LMP □ Other			Nipple Dischaus:	Drauge DIMP Dother

Patient Signature______ Date _____