Patient History Questionnaire

Today's Date ________________

____ _________ ______________________________
Patient Name **Age** **Date of Birth (Month/day/year)**

_______________________________________ Currently working? ____________ Since __________________
Occupation/Student month/day/year

ARE YOU AN ATHLETE? _________ If YES, Which SPORT(s) ____

High School ___________________________ College __________________________ Professional ____________________________

_______ft________in ____________lbs (circle one)
HEIGHT **WEIGHT** **Left handed** **Right Handed**

CHIEF COMPLAINT (Explain why you are here, include symptoms, body part, etc.)
____
____

IS THIS AN INJURY? _________ **If yes, DATE OCCURRED** _____________ **WORK RELATED?** __________

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?

______**Suddenly** ______ **Pulling** ______ **Work Injury**

______ **Lifting** ______ **Fall** ______ **Sports Injury**

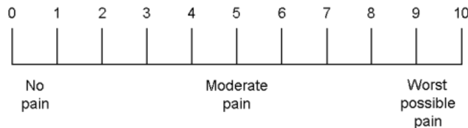
______ **Auto Accident**

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** **Night**



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 ____ YES / NO
____OCCUPATIONAL THERAPY ____ YES / NO
____MEDICATIONS ____ YES / NO
____INJECTIONS ____ YES / NO
____BRACES ____ YES / NO
____ORTHOTICS or SPECIAL SHOES ____ YES / NO

PAST MEDICAL HISTORY:

PLEASE LIST/DESCRIBE PAST MEDICAL PROBLEMS:

____

____

____

PLEASE LIST TYPE AND YEAR OF PREVIOUS SURGERIES:

____________________ ____________________ ____________________

____________________ ____________________ ____________________

WHAT MEDICATIONS DO YOU TAKE?

____________________ ____________________ ____________________

____________________ ____________________ ____________________

ARE YOU ALLERGIC TO: **PLEASE DESCRIBE YOUR REACTION:**

☐**Medications** ____________________ ____________________

____________________ ____________________

☐**Tape** ☐**Iodine** ☐**Latex** ☐**Other** ____________________

DO YOU HAVE A FAMILY HISTORY OF:

☐**Heart Disease** **Mother**☐ **Father**☐ **Other** ____________________

☐**Diabetes** **Mother**☐ **Father**☐ **Other**____________________

☐**Other Illness** ____________________ **Mother**☐ **Father**☐ **Other** ____________________

____________________ **Mother**☐ **Father**☐ **Other** ____________________

Do you Smoke? ☐**Yes** ☐**No** ☐**Cigarettes** ☐**Cigar** ☐**Pipe** **How many per day?** __________ **# of Years** __________

Have you Quit? ☐**Yes** ☐**No** **How long?** __________

Do you drink Alcohol? ☐**Yes** ☐**No** **How Often?** __________

Do you use OTC/Herbal Supplements? ☐**Yes** ☐**No** **Type/Frequency** ____________________

Do you use illegal substances? ☐**Yes** ☐**No** **Type/Frequency** ____________________

REVIEW OF SYSTEMS: (PLEASE CHECK ANY HEALTH PROBLEMS IN THE FOLLOWING AREAS)

HEART	MUSCULOSKELETAL	RESPIRATORY	ENDOCRINE
☐Coronary Artery ase ☐Hypertension ☐High Cholesterol ☐Heart Mumur ☐Other	☐ Osteoarthritis ☐Osteoporosis ☐Chronic Muscle Pain ☐Swollen Joints ☐Other	☐Asthma ☐Emphysema ☐Sleep Apnea ☐Shortness of Breath ☐ Other	☐Thyroid Disease ☐Diabetes Type I Type II ☐Excessive Weight Loss ☐Excessive Weight Gain ☐Other
NEURO	**VASCULAR**	**HEENT**	**URINARY**
☐Numbness ☐Seizure Disorder ☐Tremors ☐Stroke ☐Other	☐Phlebitis ☐Clotting/Bleeding Problems ☐Easy Bruising ☐Other	☐Blurry Vision ☐Hearing Loss ☐Ring in Ears ☐Pain with Swallowing ☐Other	☐Frequent ☐Burning ☐Blood in Urine ☐Kidney Stone ☐Other
SKIN	**GASTROINESTINAL**	**PSYCHIATRIC**	**GENERAL**
☐Rash ☐Psoriasis ☐Lesions ☐Moles ☐Other	☐Reflux ☐Peptic Ulcer ☐Hepatitis ☐Gallstones ☐Other	☐Anxiety ☐Depression ☐Schizophrenia ☐ADHD ☐Other	☐Cancer __________ ☐Fever ☐Chills ☐Night Sweats ☐HIV ☐OTHER __________
GENITALS/BREAST ☐Tumor ☐Erectile Dysfunction ☐Large Prostate ☐Nipple Discharge ☐Menopause ☐LMP ☐Other			

Patient Signature____________________ **Date** ____________________