

PATIENT HISTORY QUESTIONNAIRE

NAME: _____ AGE: _____ TODAYS DATE: _____

ARE YOU RIGHT OR LEFT HANDED: _____ OCCUPATION: _____

REASON FOR VISIT: _____

WHO REFERRED YOU HERE: _____ WORK RELATED INJURY: Y N

TREATING PHYSICIANS: _____

WHAT HURTS: _____ DURATION (how long this has been going on) _____

PAIN LEVEL: 1-10 _____ (1 is the least pain, 10 is the worst pain)

TYPE OF PAIN: Dull Sharp Throbbing Achy Stabbing Shooting Other _____
(circle all that apply)

Do you get any of the following: (circle all that apply)

Numbness Tingling Weakness Night Pain Clicking Stiffness
Popping Instability Loss of Range of Motion Swelling Catching

Pain with: Squatting Weight Bearing Activities At Rest Climbing Stairs
Overhead Activities Throwing Lifting Carrying Reaching

Other Symptoms: _____

What treatments have you had for this problem: X-ray's MRI Physical Therapy Ice Heat
(circle all that apply) Medications Injections Surgery Other _____

PAST HISTORY

Medical History: (Please circle Yes or No for the following medical conditions)

High Blood Pressure	Yes	No	Diabetes	Yes	No	Heart Trouble	Yes	No
Respiratory Problems	Yes	No	Stroke	Yes	No	Cancer	Yes	No
Bleeding Problems	Yes	No	HIV/AIDS	Yes	No	Stomach Problems	Yes	No
Hepatitis	Yes	No	Blood Clots	Yes	No	Sleep Apnea	Yes	No
Latex Allergy	Yes	No	Thyroid problems	Yes	No	Other	_____	

CURRENT MEDICATIONS (dose and how many times per day)

DRUG ALLERGIES: _____

PAST SURGERIES/HOSPITALIZATIONS AND APPROXIMATE DATES:

IS THERE ANY FAMILY HISTORY OF: (any medical problems in your blood relatives)

- Diabetes Mellitus
- Heart Problems
- Cancer
- High Blood Pressure
- Arthritis
- Other _____

SOCIAL HISTORY:

- Marital status: Single Married Separated Divorced Widowed
- Tobacco Use: Never Currently Smoke, how may per day _____ Quit/ when _____
- Alcohol Use: Never Rarely Moderate Daily (how much) _____
- Drug Use: Never Type and Frequency _____

REVIEW OF SYSTEMS:

- | | | | | |
|--|--|--|--|---|
| Constitutional: <ul style="list-style-type: none"><input type="checkbox"/> Fevers<input type="checkbox"/> Chills<input type="checkbox"/> Night Sweats<input type="checkbox"/> Weight Loss<input type="checkbox"/> Weight Gain | Eyes & ENT: <ul style="list-style-type: none"><input type="checkbox"/> Blurred Vision<input type="checkbox"/> Double Vision<input type="checkbox"/> Difficulty Swallowing<input type="checkbox"/> Hoarseness | Cardiovascular: <ul style="list-style-type: none"><input type="checkbox"/> Chest Pain<input type="checkbox"/> Leg Swelling<input type="checkbox"/> Shortness of Breath<input type="checkbox"/> Cough<input type="checkbox"/> Wheezing | Gastrointestinal: <ul style="list-style-type: none"><input type="checkbox"/> Heartburn<input type="checkbox"/> Abdominal Pain | Genitourinary: <ul style="list-style-type: none"><input type="checkbox"/> Difficulty Urinating<input type="checkbox"/> Frequent Urinating<input type="checkbox"/> Other? _____ |
| Psychiatric: <ul style="list-style-type: none"><input type="checkbox"/> Depression<input type="checkbox"/> Anxiety<input type="checkbox"/> Mood Swings<input type="checkbox"/> Suicidal Thoughts | Neurological: <ul style="list-style-type: none"><input type="checkbox"/> Difficulty Walking<input type="checkbox"/> Tingling<input type="checkbox"/> Incoordination<input type="checkbox"/> Seizures | Hematological: <ul style="list-style-type: none"><input type="checkbox"/> Easy Bleeding<input type="checkbox"/> Fatigue | Integument: <ul style="list-style-type: none"><input type="checkbox"/> Skin Lesions<input type="checkbox"/> Rash<input type="checkbox"/> Other? _____ | Musculoskeletal: <ul style="list-style-type: none"><input type="checkbox"/> Diffuse Joint Pain<input type="checkbox"/> Focal Joint Pain<input type="checkbox"/> Muscular Swelling<input type="checkbox"/> Muscle Pain |