MEDICAL HISTORY QUESTIONNAIRE

Name:____ Date:______________________

Date of Birth:________________ Age:_____ Height:______ Weight:______lbs. ☐ Male ☐ Female

Referring Physician:________________________________ Primary Physician:_________________________________

Why are you seeing the doctor today? ____

____

How long has this problem (pain) been present? ____

Has the problem (pain) worsened recently? ☐No ☐Yes, how recently? ____

What started the problem (pain)? ____

Location of problem (pain)? _______________________________ Quality? ☐Sharp ☐Burning ☐Dull ☐Aching

How severe is the problem (pain) ? ☐ Mild ☐Moderate ☐Severe

What makes the problem (pain) better? ____

Treatment included? (Check all that apply)

☐ **NO** medicines, therapy, manipulations, injections, braces or casts.

☐ Physical Therapy/Exercise ☐Manipulation ☐ Narcotic Medication ☐ Cast ☐Steroid Injections

☐ Massage/Ultrasound ☐TENS Unit ☐ Traction ☐ Braces ☐ Anti-inflammatories

Other:____

Previous physicians consulted for this problem

Physician	Specialty	City	Treatments

Have you had any tests to evaluate your problem? (Check all that apply)

☐ Plain X-rays ☐MRI ☐ CT Scan ☐Bone Scan ☐EMG ☐ Other-Specify ____________________

If YES, when: ___________________________where:____

Medications you are taking including over-the-counter☐ None (If you brought a list, give copy to nurse)

Medication	Dose	How long have you been taking?

Do you have any allergies? ☐No ☐Yes If yes, please list:____

____

Medical History

Illness / Injury	Yes	No	Illness / Injury	Yes	No
High Blood Pressure			Kidney Disease		
Diabetes			Liver Disease		
Heart Attack			Females ONLY: Are you or could you be pregnant?		
Chest Pain or Angina			AIDs or HIV Infection		
Stroke			Thyroid Problems		
Cancer			Shortness of Breath		
Hepatitis			Blood Clots		
Stomach Ulcers			Bleeding Tendency		
Arthritis			Seizures		
Gout			Accidents / Broken Bones (please list)		
Anesthetic Complications					

Is your primary physician aware of the above problems to which you answered yes? No ☐Yes ☐

Are you having any other problems that were not listed above? ☐ No ☐ Yes, please explain:________________________

____

Have you ever had general anesthesia? ☐No ☐Yes If Yes, any problems related to this? ☐No ☐ Yes

Please explain any problems related to general anesthesia:____

____

Surgical History

Hospital / Surgeon	Date	Type of Surgery

Family History (Do you have a family history of any of the following illnesses?)

Illness	Yes	No	Illness	Yes	No
Cancer			Rheumatoid Arthritis		
Heart Disease			Degenerative Arthritis		
High Blood Pressure			Thyroid Disease		
Diabetes			Immune Disorders		
Blood Clots					

Social History

☐ Work in the home ☐ Employed (occupation):___________________________ ☐ Student ☐ Retired ☐Disabled

Do you live alone? ☐ No ☐ Yes

Are you currently in an exercise program or any sports activities? ☐Daily ☐Weekly ☐Monthly ☐ Rarely ☐Never

If yes, what type____

History of substance abuse? ☐ No ☐ Yes If Yes, explain____

Currently smoking? ☐No ☐ Yes If yes, (# of packs) _______ per day for _______ years

Quit smoking? ☐ This year ☐ More than 1 yr ago ☐More than 5 yrs ago ☐More than 10 yrs ago

If you previously smoked, (# of packs) __________ per day for ___________ years

Drink Alcohol? ☐ Daily ☐1-2 times per week ☐1 -2 times per month ☐1 – 2 times per year