MEDICAL HISTORY QUESTIONNAIRE

DATE: _____

NAME: _____ DOB: _____ AGE: _____ HEIGHT _____ WEIGHT_____

EMERGENCY CONTACT NAME:_____ PHONE NUMBER:_____

WHAT ARE YOUR MAIN PROBLEMS OR COMPLAINTS?

_____

_____

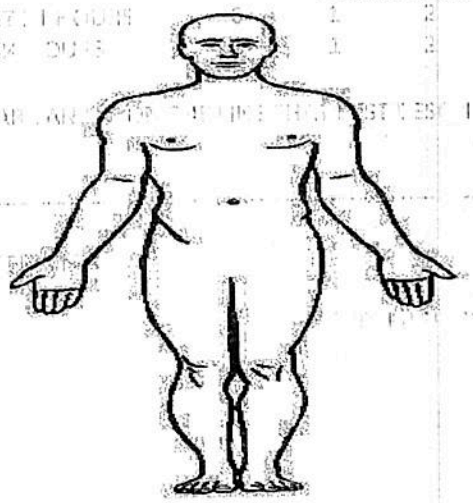
ONSET DATE: _____ SURGERY DATE: _____

WAS THERE TRAUMA WITH YOUR COMPLAINT?	YES	NO
IS THERE PAIN ASSOCIATED WITH YOUR COMPLAINT?	YES	NO
HAVE YOU EXPERIENCED UNEXPECTED WEIGHT LOSS?	YES	NO
DO YOU HAVE PAIN THAT WAKES YOU AT NIGHT?	YES	NO
DOES YOUR PAIN VARY AND CHANGE WITH POSITION CHANGE?	YES	NO
DO YOU CURRENTLY, OR HAVE RECENTLY HAD A FEVER OR BEEN ILL?	YES	NO
DO YOU HAVE NUMBNESS AND/OR TINGLING IN YOUR ARMS OR LEGS?	YES	NO
DO YOU HAVE LEG WEAKNESS OR "GIVING AWAY"?	YES	NO
HAVE YOU RECENTLY FALLEN (WITHIN THE LAST 12 MONTHS) OR HAD DIFFICULTY WALKING?	YES	NO
IF YOU HAVE FALLEN (WITHIN THE LAST 12 MONTHS), WERE YOU INJURED?	YES	NO
DO YOU CURRENTLY HAVE, OR EVER BEEN TOLD YOU HAVE AN INFECTIOUS DISEASE?	YES	NO

INSTRUCTIONS: PLEASE MARK YOUR SYMPTOMS ON THE BODY SHOWN BELOW. USE THE FOLLOWING MARKINGS:

√√√√ for Sharp Pain ooooo for Dull Pain ///// for Numb Areas +++++ for Tingling Areas

Draw arrow for Radiating Pain ←↑↓→



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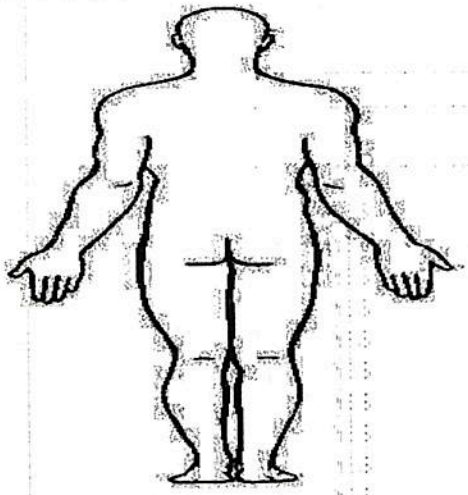

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PLEASE RATE YOUR PAIN BELOW: ***0=NO PAIN*** AND ***10=SEVERE PAIN*** (10 IS PAIN THAT WOULD SEND YOU TO THE HOSPITAL)

CURRENTLY	0	1	2	3	4	5	6	7	8	9	10
WORST IN PAST 24 HOURS	0	1	2	3	4	5	6	7	8	9	10
BEST IN PAST 24 HOURS	0	1	2	3	4	5	6	7	8	9	10

PLEASE MARK AN "X" ON THE LINE THAT BEST DESCRIBES YOUR OVERALL LEVEL OF DIFFICULTY WITH YOUR DAILY ACTIVITIES

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EXTREME DIFFICULTY NO DIFFICULTLY

PLEASE CONTINUE ON OTHER SIDE

PLEASE LIST ANY DIAGNOSTIC TESTS (XRAY, MRI, ETC) YOU MAY HAVE HAD AND RESULTS:

_____

_____

DO YOU SMOKE OR USE ANY TOBACCO PRODUCTS? YES NO PACKS/DAY_____
DO YOU DRINK ALCOHOL? YES NO DRINKS/WEEK_____
PER OCCASION_____
DO YOU EXERCISE REGULARLY? YES NO DAYS/WEEK_____
DO YOU HAVE ANY ALLERGIES? (EXAMPLES: LATEX, ADHESIVES, CORTISONE) YES NO
**IF"YES", LIST BELOW:*

_____

DO YOU OR ANY IMMEDIATE FAMILY MEMBER HAVE OR EVER HAD ANY OF THE FOLLOWING? PLEASE MARK **ALL** THAT APPLY. PLACE A "X" IN THE FAMILY BOX (BROTHER, SISTER, PARENT OR GRANDPARENT) AND/OR IN THE PERSONAL HISTORY BLOCK.

CONDITION	FAMILY	PERSONAL	CONDITION	FAMILY	PERSONAL
HEART CONDITION			SEIZURES		
CHEST PAIN			THYROID DISEASE		
HEART ATTACK			BOWEL OR BLADDER PROBLEMS		
PACEMAKER / DEFIBRILLATOR			ABDOMINAL PAIN		
HIGH BLOOD PRESSURE			RECTAL BLEEDING		
LOW BLOOD PRESSURE			HEADACHES		
HIGH CHOLESTEROL			NAUSEA OR VOMITING		
STROKE			BLOOD CLOTS / VASCULAR PROBLEMS		
BREATHING DIFFICULTIES			RHEUMATOID ARTHRITIS		
LUNG DISEASE			OSTEOARTHRITIS		
CANCER			OSTEOPOROSIS		
DIABETES			OSTEOPENIA		
KIDNEY DISEASE			LOSS OF VISION ONE OR BOTH EYES		
DIZZINESS / VERTIGO			ANXIETY		
POSTURAL HYPOTENSION			DEPRESSION		
HEARING LOSS			OTHER:		

ARE THERE ANY OTHER CONDITIONS OR DISEASES NOT LISTED ABOVE THAT YOU HAVE OR HAVE HAD? PLEASE LIST BELOW:

_____

ARE YOU CURRENTLY BEING SEEN BY A PHYSICIAN OR OTHER MEDICAL PROFESSIONAL FOR THE ITEMS MARKED? YES NO

WHEN WAS YOUR LAST MEDICAL CHECKUP? _____ DO YOU HAVE AN UPCOMING APPOINTMENT? YES NO

DURING THE PAST MONTH, HAVE YOU OFTEN BEEN BOTHERED BY FEELING DOWN, DEPRESSED, OR HOPELESS? YES NO
DURING THE PAST MONTH, HAVE YOU OFTEN BEEN BOTHERED BY LITTLE INTEREST OR PLEASURE IN DOING THINGS? YES NO

PLEASE LIST ALL YOUR MEDICATIONS:

_____
_____
_____
_____
_____

LIST ANY & ALL SURGERIES OR SIGNIFICANT INJURIES:
(ALONG WITH THE APPROXIMATE DATE)

_____
_____
_____
_____
_____

FOR FEMALE PATIENTS:
HAVE YOU HAD ANY CHANGES TO YOUR MENSTRUAL CYCLE? YES NO
ARE YOU PREGNANT OR POSSIBLY PREGNANT; OR ARE YOU BREASTFEEDING? YES NO
IF YOU ARE PREGNANT, WHAT IS YOUR EXPECTED DUE DATE? _____