MEDICAL HISTORY QUESTIONNAIRE

Name: _____, _____ Date: _____
Last First

Age: _____ Date of Birth: _____ Height: _____ Weight: _____ Hand Dominance: Right ☐ Left ☐

Primary Care Physician: _____ Referring Physician: _____

HISTORY OF PRESENT INJURY OR ILLNESS

Which body parts would you like to have evaluated? _____

_____

On what date did your symptoms begin? _____

Did you have an injury? Yes ☐ No ☐ Date of injury: _____ Is the injury work-related? Yes ☐ No ☐ N/A ☐

How did the injury occur? Please be specific. _____

_____

What body parts were injured? _____

COURSE OF TREATMENT

Have you ever seen another physician/healthcare provider in relation to this injury or illness? Yes ☐ No ☐

If yes, please provide physician's/provider's name: _____

Are you currently being treated for this injury or illness? Yes ☐ No ☐

If yes, please provide physician's/provider's name: _____

What treatments, if any, have you received for this injury or illness?

Medication ☐ Physical Therapy ☐ Pain Management ☐ Cortisone Shots ☐ Casting ☐ Bracing ☐

Have you ever had surgery for this injury or illness? Yes ☐ No ☐ If yes, please indicate:

Date/Year	Procedure	Date/Year	Procedure
_____	_____	_____	_____
_____	_____	_____	_____

What diagnostic studies, if any, have you had for this injury or illness?

X-rays ☐ MRI ☐ CT scan ☐ EMG/NCV ☐ Bone scan ☐ Discogram ☐

PATIENT COMPLAINTS

Body part(s):	What symptoms are you presently having in the body part(s)?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PAST MEDICAL HISTORY

ACCIDENTS/INJURIES

Prior to this injury or illness, did you ever have injury to these body parts that was work-related? Yes ☐ No ☐

Prior injuries, work-related:

Body part(s) injured (be specific, e.g., neck, upper Back, lower back, specific part of extremity)	Date	Employer

Prior to this injury or illness, did you ever have injury to these body parts that was not work-related? Yes ☐ No ☐

Prior injuries, not work-related:

Body part(s) injured (be specific, e.g., neck, upper Back, lower back, specific part of extremity)	Date

MEDICAL ILLNESSES

Do you have any of the following conditions?

High Blood Pressure	Yes ☐ No ☐	Heart Disease	Yes ☐ No ☐	Cancer	Yes ☐ No ☐
Thyroid Disease	Yes ☐ No ☐	Stroke	Yes ☐ No ☐	What Type?	_____
Diabetes Mellitus	Yes ☐ No ☐	Ulcer	Yes ☐ No ☐	Arthritis	Yes ☐ No ☐
Kidney Disease	Yes ☐ No ☐	Lupus	Yes ☐ No ☐	What Type?	_____
Seizure Disorder	Yes ☐ No ☐	Emphysema	Yes ☐ No ☐	Asthma	Yes ☐ No ☐

Have you ever been diagnosed with HIV/AIDS? Yes ☐ No ☐

Have you ever been diagnosed with chronic hepatitis? Yes ☐ No ☐ Which hepatitis, A, B, or C? _____

PREVIOUS SURGERIES/HOSPITALIZATIONS

What surgeries (other than those previously listed) have you had in the past? _____

What hospitalizations have you had in the past? _____

CURRENT MEDICATIONS

Name of Medication	Dosage/Frequency	Name of Medication	Dosage/Frequency

ALLERGIES

Do you have any allergies to medication or other substances? Yes ☐ No ☐

If yes, please list and describe reaction: _____

FAMILY HISTORY

Which medical illnesses does your mother have? (please check which apply)

High Blood Pressure	_____	Heart Disease	_____	Cancer	_____
Thyroid Disease	_____	Stroke	_____	What Type?	_____
Diabetes Mellitus	_____	Ulcer	_____	Arthritis	_____
Kidney Disease	_____	Lupus	_____	What Type?	_____
Seizure Disorder	_____	Emphysema	_____	Asthma	_____

Which medical illnesses does your father have? (please check which apply)

High Blood Pressure	_____	Heart Disease	_____	Cancer	_____
Thyroid Disease	_____	Stroke	_____	What Type?	_____
Diabetes Mellitus	_____	Ulcer	_____	Arthritis	_____
Kidney Disease	_____	Lupus	_____	What Type?	_____
Seizure Disorder	_____	Emphysema	_____	Asthma	_____

SOCIAL HISTORY

Employer: _____ Occupation/Job Title: _____

Job Duties: _____

Do you use the following?

Alcohol Yes ☐ No ☐ How often? _____ drinks per (day/week/month). How many years? _____

(please circle)

Cigarettes Yes ☐ No ☐ How many packs per day? _____ How many years? _____

Recreational Drugs Yes ☐ No ☐ How often? _____ How many years? _____

Please list which recreational drug(s): _____

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Do you have children? Yes ☐ No ☐ How many? _____

REVIEW OF SYSTEMS

Do you CURRENTLY have? (if yes, please check appropriate boxes)

GENERAL
- ☐ Fever
- ☐ Chills
- ☐ Weight loss
- ☐ Fatigue

SKIN
- ☐ Nail changes
- ☐ New lesions
- ☐ Rash
- ☐ Skin color changes

HEENT
- ☐ Double vision
- ☐ Eye pain
- ☐ Eye redness
- ☐ Decreased hearing
- ☐ Earache
- ☐ Ear ringing
- ☐ Nosebleeds
- ☐ Dry mouth
- ☐ Hoarseness
- ☐ Oral ulcers
- ☐ Sore throat

RESPIRATORY
- ☐ Chronic cough
- ☐ Decreased exercise tolerance
- ☐ Difficulty breathing
- ☐ Coughing up blood
- ☐ Sputum production
- ☐ Wheezing

BREAST
- ☐ Breast mass
- ☐ Breast pain
- ☐ Nipple discharge
- ☐ Skin changes

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Leg pains with walking
- ☐ Leg swelling
- ☐ Night awakening due to trouble breathing
- ☐ Palpitations
- ☐ Shortness of breath

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Rectal bleeding
- ☐ Trouble swallowing
- ☐ Reflux

GENITOURINARY
- ☐ Vaginal discharge
- ☐ Menstrual irregularities
- ☐ Difficulty starting/stopping urinary stream
- ☐ Painful urination
- ☐ Change in urinary stream
- ☐ Increased frequency
- ☐ Blood in urine
- ☐ Loss of bladder control
- ☐ Nighttime urination
- ☐ Urinary retention
- ☐ Urethral discharge
- ☐ Impotence
- ☐ Penile lesions
- ☐ Testicular mass
- ☐ Testicular pain

MUSCULOSKELETAL
- ☐ Neck pain
- ☐ Low back pain
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Joint swelling

NEUROLOGICAL
- ☐ Loss of bowel control
- ☐ Dizziness/vertigo
- ☐ Headaches
- ☐ Numbness/tingling
- ☐ Passing out
- ☐ Seizures
- ☐ Tremor

PSYCHIATRIC
- ☐ Anxiety
- ☐ Change in sleep pattern
- ☐ Depression
- ☐ Hallucinations
- ☐ Suicidal thoughts

ENDOCRINE
- ☐ Appetite changes
- ☐ Cold intolerance
- ☐ Increased thirst
- ☐ Increased urination
- ☐ Hair changes
- ☐ Sexual dysfunction

HEMATOLOGY
- ☐ Easy bruising
- ☐ Enlarged lymph nodes
- ☐ Prolonged bleeding

If you have completed all sections in the above form and all responses are true to the best of your knowledge, please sign and date below.

Signature: _____ **Date:** _____