Patient Questionnaire

Name:	Date of Visit: / /
Age:	Date of Birth: / /
Height: feet inches	Weight: pounds
Dominant hand: right left (circle one)	
Who is your primary physician or family doctor? Who is the referring doctor?	

Is this visit for a **work-related** injury or condition? yes no (circle one)	Date of injury: / /
If yes, who is your **Employer**?	

Have we treated anyone in your family? yes no (circle one) If yes, who?

History of Present Illness: (What is the reason for this visit? Describe the onset, quality, location, duration, timing, and severity of symptoms and any treatments tried to date.)

Past Medical and Surgical History: (What other medical problems do you have or have you had? Describe past experience with illnesses, injuries, and treatments including any operations or surgery.)

Are you allergic to any medication, or do any medications make you sick? (please list)

-
-
-
-
-
-

What Medications do you take? (Please list each medication and dosage)

-
-
-
-
-
-
-
-

Have you or any family member had problems with surgical anesthesia? yes no (circle one) (Describe)

Have you ever taken prednisone or other steroid by mouth? yes no (circle one)

Have you ever had a cortisone or other steroid injection? yes no (circle one)

Social history (circle one)
Work: Student Unemployed Homemaker Retired Employed ( )
Marital Status: Single Married Separated Divorced Widowed
Alcohol intake: Never Rarely Moderately Daily
Tobacco: Cigarettes (packs/day) Never smoked Quit (date: / /) Chew

Please continue on other side of page…

Family History

Mother: Alive Deceased (circle one) Current health or cause of death: ____

Father: Alive Deceased (circle one) Current health or cause of death: ____

Siblings: #Alive __________ Health Problems ____

Deceased_______ Cause of death ____

Children: #Alive __________ Health Problems ____

Deceased_______ Cause of death ____

Check any illness that has occurred in any of your blood relatives (*not you – your section is below*):

Disease	**Who**	**Disease**	**Who**
_____Tuberculosis (TB)	______________________________	_____Bleeding disorder/blood clots	__________________
_____Diabetes	______________________________	_____Kidney disease	__________________
_____Stroke	______________________________	_____Depression/Anxiety	__________________
_____High blood pressure	______________________________	_____Arthritis/Gout	__________________
_____Migraines	______________________________	_____Thyroid disease	__________________
_____Heart disease	______________________________	_____Cancer (type)	__________________
_____Liver disorder	______________________________	_____Hepatitis	__________________
_____Other	______________________________		

System review: ***Do you or have you ever had any of these***? (Check all that apply)

- ☐ Recent weight change
- ☐ Stiff neck
- ☐ Jaundice
- ☐ Double vision
- ☐ nose bleed
- ☐ asthma or wheezing
- ☐ pneumonia or bronchitis
- ☐ chest pain or angina
- ☐ heart attack
- ☐ high blood pressure
- ☐ thyroid disease
- ☐ hormone therapy
- ☐ liver disease
- ☐ gallbladder disease
- ☐ weakness of muscles or joints
- ☐ pain with walking relieved by rest
- ☐ convulsions or seizures
- ☐ wound healing problems
- ☐ blood clots
- ☐ anemia or blood deficiency
- ☐ headaches
- ☐ flu-like aches
- ☐ glaucoma
- ☐ loss of vision
- ☐ sinus infection or disorder
- ☐ shortness of breath
- ☐ difficulty breathing
- ☐ heart murmur or arrhythmia
- ☐ heart failure
- ☐ cancer (type:____________________)
- ☐ diabetes
- ☐ peptic ulcer (stomach or duodenum)
- ☐ hepatitis
- ☐ kidney disease
- ☐ difficulty walking
- ☐ psychiatric problems or care
- ☐ paralysis
- ☐ skin ulceration or breakdown
- ☐ abnormal bleeding
- ☐ immune deficiency

Women Only

Date of last menstrual period: / /

Have you ever had a bone density screening? Yes No (circle one)

If yes, when? / / Where?

Who filled out this form?

- ☐ Patient
- ☐ Other (describe relation)

Patient Signature:____

Date: ____