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?

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

Have we treated anyone in your family? ❑ yes ❑ no 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 medications,** or do any medications make you sick? (Please list)

-
-
-
-

What **medications** do you take? (Please list each medication and dosage.)

-
-
-
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-
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-
-

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

Have you **ever taken prednisone** or other steroid by mouth? ❑ yes ❑ no
Have you ever had a **cortisone or other steroid injection?** ❑ yes ❑ no

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 complete the back side. →

Family History

Mother: ❑ Alive ❑ Deceased Current health or cause of death ____________________

Father: ❑ Alive ❑ Deceased 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 anyof you blood relative

	Disease	Who		Disease	Who
____	Tuberculosis	____________	____	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 those 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
- ❑ gall bladder 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 (list 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

If yes **when?** / / **Where?**

Who filled out this form?

❑ Patient ❑ Other (Describe relation)

Patient Signature:____

Form revised 02-09 Both sides of form reviewed by physician:________________