

Welcome to our office. Please help us help you by providing your medical history.

Medical Questionnaire

Name _____ Date of Birth _____ Age _____ Gender: M F

| | | |
|--|------------------|----------------------------------|
| <u>What are your symptoms?</u> | Date began _____ | Do NOT write in this area |
| What was the cause of these symptoms? | | |
| Were these symptoms caused by a motor vehicle accident? No Yes | | |
| Were these symptoms caused by an accident On the Job? No Yes | | |
| If you answered yes to either, describe what happened: | | |

What treatments have you had for this problem?

Check **No** or **Yes** and give date(s), location, and how it helped (or didn't help):

| | | | | |
|----|-----|--------------------|----------|-----------|
| No | Yes | Physical Therapy | Date(s) | Location: |
| | | Did it help? | | |
| | | Chiropractic | Date(s): | Location: |
| | | Did it help? | | |
| | | Epidural Injection | Date(s): | Location: |
| | | Did it help? | | |
| | | Surgery | Date(s): | Location: |
| | | Did it help? | | |
| | | Other Treatments | Date(s): | Location: |
| | | Type of Treatment: | | |
| | | Type of Treatment: | | |
| | | Did it help? | | |

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Your Health History

Check **No** or **Yes** for any of the following medical or surgical conditions:

| No | Yes | Condition / Procedure | Year of diagnosis or procedure |
|----|-----|--|---|
| | | Obesity | |
| | | Diabetes | |
| | | Heart Problems | |
| | | Heart Attack | |
| | | Stroke | |
| | | Ulcer | |
| | | Lung Problems or Asthma | |
| | | High Blood Pressure | |
| | | Depression | |
| | | Cancer | Type of Cancer |
| | | Hepatitis | |
| | | Gall Bladder Removed | |
| | | Lung Surgery | |
| | | Stent in Coronary Artery | |
| | | Open Heart Surgery | Circle types: Cardiac Bypass Valve Replacement Pacemaker |
| | | Hysterectomy (female) | |
| | | Prostate Operation (male) | |
| | | Bone/ Joint Surgery | Type _____ Type _____ |
| | | Spine Surgery | Type _____ Type _____ |
| | | Describe any other important Conditions / Surgery/ Hospitalizations: | |

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Your Other Symptoms

Check **No** or **Yes** for symptoms you have had in last 6 months and give details

| No | Yes | Symptom | Details |
|----|-----|---------------------------|---------|
| | | Dizziness | |
| | | Headaches | |
| | | Vision Problems | |
| | | Cough | |
| | | Shortness of breath | |
| | | Chest pain | |
| | | Swelling in ankles | |
| | | Heartburn | |
| | | Nausea | |
| | | Diarrhea /Constipation | |
| | | Bleeding in stools | |
| | | Pain with urination | |
| | | Difficulty with urination | |
| | | Urgency to void | |
| | | Incontinence | |
| | | Skin rash or lesion | |
| | | Numbness | |
| | | Joint pain | |
| | | Depression | |
| | | Insomnia | |
| | | Anxiety | |
| | | Weight Loss | |
| | | Weight Gain | |
| | | Fevers/ Chills | |
| | | Other problems | |

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List ALL MEDICATIONS that you take - names and dosages (or attach a list)

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Medical Allergies - List ALL medications that you are allergic to and the reaction you had when you received it:

Your Family History

Check off the conditions that run in your family:

List the family member (e.g. mother, father, sibling, etc) who has or had the condition.

| No | Yes | Condition | Which family member(s)? |
|----|-----|--------------------|-------------------------|
| | | Heart Disease | |
| | | Stroke | |
| | | Cancer | |
| | | Arthritis | |
| | | Spine Disc Disease | |
| | | Scoliosis | |
| | | Other Condition | |

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Your Health Habits

Smoking History Circle one: Never Past (Date Quit _____) Current

Alcohol Use Circle one: Rare/never Occasional Frequent

Exercise Circle one: Rare/never Occasional Frequent

Type(s) of Exercise: _____

Recreation/ Hobby List the things you can **no longer do** because of **this** problem

Your Social History

Marital Status Married Unmarried (Optional: Single Divorced Widow)

Work Status Full time - regular duty Type of work _____

Part time - regular duty Type of work _____

Limited Duty Date began: _____

Off of work/ temporary disability Date began: _____

Retired with permanent disability Date: _____

Retired without disability Date: _____

Homemaker

Self Employed Type of business: _____

Unemployed Type of work done _____

Other work situation _____

I certify that the above history is true and complete to the best of my ability:

Patient signature: _____ Date _____

Name of person filling out form (if not the patient): _____

Relationship to Patient _____

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Name: _____

Pain and Symptom Diagram

Please fill in the diagram by marking the location of your symptoms – Use the Key as a guide:

Please enter the following vital signs: Your Height _____ Your Weight _____

Patients Signature: _____ Date _____

Name of person filling out diagram (if not patient): _____

Relationship to Patient _____