PATIENT HISTORY QUESTIONNAIRE

NAME:_____ AGE_____ TODAYS DATE:_____

ARE YOU RIGHT OR LEFT HANDED:_____ OCCUPATION:_____

REASON FOR VISIT:_____

_____

WHAT HURTS:_____ DURATION (how long this has been going on)_____ _____

PAIN LEVEL: 1-10_____(1 is the least pain, 10 is the worst pain)

TYPE OF PAIN: Dull Sharp Throbbing Achy Stabbing Shooting Other_____
(circle all that apply)

Do you get any of the following: (circle all that apply)

Numbness Tingling Weakness Night Pain Clicking Stiffness
Popping Instability Loss of Range of Motion Swelling Catching

Pain with: Squatting Weight Bearing Activities At Rest Climbing Stairs
Overhead Activities Throwing Lifting Carrying Reaching

Other Symptoms:_____

What treatments have you had for this problem: X-ray's MRI Physical Therapy Ice Heat
(circle all that apply)
Medications Injections Surgery Other_____

PAST HISTORY
Medical History: (Please circle Yes or No for the following medical conditions)

High Blood Pressure	Yes	No	Diabetes	Yes	No	Heart Trouble	Yes	No
Respiratory Problems	Yes	No	Stroke	Yes	No	Cancer	Yes	No
Bleeding Problems	Yes	No	HIV/AIDS	Yes	No	Stomach Problems	Yes	No
Hepatitis	Yes	No	Blood Clots	Yes	No	Sleep Apnea	Yes	No
Latex Allergy	Yes	No	Thyroid problems	Yes	No	Other _____		

CURRENT MEDICATIONS (dose and how many times per day)

_____ _____ _____

_____ _____ _____

DRUG ALLERGIES: _____

PAST SURGERIES/HOSPITALIZATIONS AND APPROXIMATE DATES:

_____

_____

FAMILY HISTORY: (any medical problems in your blood relatives)

Mother:_____ Father:_____ Siblings:_____

SOCIAL HISTORY: Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Tobacco Use: ☐ Never ☐ Currently Smoke, how may per day_____ ☐ Quit/ when_____
Alcohol Use: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily (how much)_____
Drug Use: ☐ Never ☐ Type and Frequency_____

Please Turn Over