PATIENT QUESTIONNAIRE

NAME:_____ AGE: _____ DOB: _____

REFERRING PHYSICIAN: _____ PRIMARY PHYSICIAN: _____

PHARMACY: _____

CHIEF COMPLAINT: _____ AFFECTED SIDE □ R □ L □ Both

IS APPT. WORK RELATED □ YES □ NO DATE AND STATE OF INJURY: _____

ACCIDENT RELATED □ YES □ NO DATE AND STATE OF ACCIDENT: _____

DATE SYMPTOMS BEGAN: _____ Description Of Symptoms:_____

PAST MEDICAL HISTORY (CHECK All THAT APPLY TO YOU) or □ *NONE APPLY*:

GENERAL
□ CANCER
□ ARTHRITIS
□ THYROID
□ DIABETES
□ DEPRESSION

CARDIOVASCULAR
□ HIGH BLOOD PRESSURE
□ HEART MURMUR
□ HEART ATTACK
□ SLEEP APNEA

GASTROINTESTINAL
□ ULCERS
□ COLITIS
□ HEARTBURN

NEUROLOGICAL
□ STROKE
□ MULTIPLE SCLEROSIS
□ PARKINSON'S DISEASE
□ SEIZURE
□ EPILEPSY
□ HEAD INJURY
□ HEADACHE/MIGRAINE
□ NECK OR BACK INJURY
□ ALZHEIMER'S

LUNGS
□ ASTHMA
□ BRONCHITIS
□ PNEUMONIA
□ TUBERCULOSIS
□ EMPHYSEMA
□ COPD

BLOOD
□ ANEMIA
□ DVT/Clots
□ AIDS
□ HEPATITIS

ORTHOPEDIC
□ GOUT
□ OSTEOARTHRITIS
□ RHEUMATOID ARTHRITIS

GENITAL/URINARY
□ KIDNEY STONES
□ UTI

□ OTHER CONDITIONS (please list) _____

PAST SURGICAL HISTORY (CHECK ANY THAT APPLY TO YOU / LIST YEAR) or □ *NONE APPLY*

□ TONSILLECTOMY _____ □ HEART SURGERY _____ □ BRAIN SURGERY_____ □ SHUNT PLACEMENT_____
□ HERNIA REPAIR _____ □ ANEURYSM REPAIR_____ □ APPENDECTOMY _____ □ ABDOMINAL SURGERY_____
□ TUBAL LIGATION _____ □ REMOVAL OF GALLBLADDER _____
□ HYSTERECTOMY – PARTIAL or COMPLETE (please circle) _____
□ REPAIR OF FRACTURES (location and year) _____
□ SPINAL SURGERY - NECK and/or LOW BACK (please circle) year? _____
□ ARTHROSCOPY – SHOULDER/KNEE/HIP (please circle) year? _____
□ JOINT REPLACEMENT – SHOULDER/KNEE/HIP (please circle) year?_____
□ OTHER INCLUDING ORTHO (please list)
_____

MEDICATIONS TAKEN DAILY (LIST ALL AND DOSES) □ *NONE*

_____ _____ _____
_____ _____ _____

ALLERGIES TO MEDICINE □YES □ NO
PLEASE LIST ALL _____

SOCIAL HISTORY:
MARITAL STATUS □ SINGLE □ MARRIED □ DIVORCED □ WIDOWED □ SEPERATED
OCCUPATION _____ □ RETIRED □ DISABLED
SMOKE □ YES □ NO PACKS PER DAY? _____ CHEW TOBACCO □ YES □ NO AMOUNT_____
ALCOHOL □ YES □ NO AMOUNT _____
ILICIT DRUGS □ YES □ NO AMOUNT _____
CAFFEINE □ YES □ NO AMOUNT _____
SPORTS ACTIVITIES: _____

FAMILY HISTORY (CHECK ANY THAT APPLY and member of family) or □ NONE APPLY
□ HIGH BLOOD PRESSURE_____ □ ALZHEIMERS_____ □ DIABETES_____
□ RHEUMATOID ARTHRITIS_____ □ HEART PROBLEMS_____ □ CANCER_____
□ BLEEDING PROBLEMS_____ □ OSTEOARTHRITIS_____ □ STROKE_____
□ MULTIPLE SCLEROSIS_____ □ PARKINSON'S_____ □ SEIZURE_____
□ COMPLICATIONS WITH ANESTHESIA_____
□ OTHER _____

REVIEW OF SYSTEMS (CHECK ANY THAT APPLY TO YOU) or □ *NONE APPLY*:

CONSTITUTIONAL
□ FATIGUE
□ WEIGHT LOSS
□ WEIGHT GAIN
□ FEVER
□ CHILLS
□ INSOMNIA

EYES
□ REDNESS
□ DRAINAGE
□ EYE PAIN
□ DOUBLE VISION

ENMT
□ EAR PAIN
□ EAR DISCHARGE
□ HEARING CHANGE
□ POST NASAL DRIP
□ SINUS PAIN/PRESSURE
□ SORE THROAT
□ TOOTH PAIN
□ SNORING

CARDIOVASCULAR
□ CHEST PAIN
□ PALPITATIONS
□ EDEMA

RESPIRATORY
□ COUGH
□ WHEEZE
□ SHORT OF BREATH
□ CONGESTION

MUSKULOSKELETAL
□ ARM PAIN
□ LEG PAIN
□ JOINT PAIN
□ BACK PAIN
□ NECK PAIN
□ WEAKNESS
□ SPASMS
□ TINGLING

NEUROLOGICAL
□ DIZZINESS
□ VERTIGO
□ LOSS OF CONSCIOUSNESS
□ GAIT DIFFICULTY
□ HEADACHES

ENDOCRINE
□ ABNORMAL THIRST
□ ABNORMAL APPETITE
□ HOT FLASHES
□ HAIR LOSS
□ HEAT/COLDSENSITIVITY

GI
□ ABDOMINAL PAIN
□ DIARRHEA
□ CONSTIPATION
□ NAUSEA
□ VOMITTING
□ HEARTBURN

INTEGUMENT
□ RASH
□ ITCHINESS
□ SKIN CHANGE

HEMATOLOGIC/ LYMPHATIC
□ LUMPS
□ SWOLLEN LYMPH GLANDS
□ BLEEDING
□ BLOOD CLOTS

PSYCHIATRIC
□ DEPRESSION
□ ANXIETY
□ ANGER
□ MANIA
□ SUICIDE IDEATION

SIGNATURE **** _____ **DATE** _____

Please list any MRIs, x-rays, CTs or other imaging you have had done in the last year:

Please list any labs you have had done in the last year:

Please list all physician's you have seen in the last year:

Please list the facility you normally have labs/images performed at:

For Office Use Only: Height_____ Weight_____ BP_____ Pulse_____