

## PATIENT QUESTIONNAIRE

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_  
AUTO ACCIDENT: YES NO WORK RELATED INJURY: YES NO  
PLACE OF INJURY: \_\_\_\_\_ Date of Injury: \_\_\_\_\_  
CHIEF COMPLAINT: \_\_\_\_\_ AFFECTED SIDE? R or L  
DESCRIBE PROBLEM: \_\_\_\_\_

**PAST MEDICAL HISTORY**     NONE APPLY or    **(CHECK ANY THAT APPLY TO YOU):**  
 HIGH BLOOD PRESSURE     HEART PROBLEMS     HEART ATTACK     STROKES  
 THYROID PROBLEMS     DIABETES     CANCER     ULCERS  
 LUNG PROBLEMS     HEPATITIS     TUBERCULOSIS     ASTHMA  
 RHEUMATOID ARTHRITIS     OSTEOARTHRITIS     PNEUMONIA     AIDS  
 EMPHYSEMA     KIDNEY STONES     BRONCHITIS  
 OTHER CONDITIONS (please list) \_\_\_\_\_

**PAST SURGICAL HISTORY**     NONE APPLY or    **(CHECK ANY THAT APPLY TO YOU / LIST YEAR):**  
 TONSILLECTOMY \_\_\_\_\_     HEART SURGERY \_\_\_\_\_     VASCECTOMY \_\_\_\_\_  
 HERNIORRAPHY \_\_\_\_\_     HEMORRHOIDECTOMY \_\_\_\_\_     APPENDECTOMY \_\_\_\_\_  
 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 and/or KNEE (please circle) year? \_\_\_\_\_  
 OTHER (please list) \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PHARMACY NAME: \_\_\_\_\_ PHONE # \_\_\_\_\_

**ALLERGIES TO MEDICINE ?**    YES    or    NO    PLEASE LIST ALL: \_\_\_\_\_

**SOCIAL HISTORY:**

SMOKE	YES or NO	PACKS PER DAY?
CHEW TOBACCO	YES or NO	AMOUNT _____
ALCOHOL	YES or NO	AMOUNT _____

**REVIEW OF SYMPTOMS**     NONE APPLY    **(CHECK ANY THAT APPLY TO YOU):**

<input type="checkbox"/> FEVER	<input type="checkbox"/> BLEEDING PROBLEMS	<input type="checkbox"/> NOSE BLEEDS
<input type="checkbox"/> CHEST PAIN	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> CONSTIPATION
<input type="checkbox"/> DIZZINESS	<input type="checkbox"/> MEMORY LOSS	<input type="checkbox"/> NIGHT SWEATS
<input type="checkbox"/> SWOLLEN ANKLES	<input type="checkbox"/> BLOOD IN URINE	<input type="checkbox"/> PAINFUL URINATION
<input type="checkbox"/> BLOOD IN STOOLS	<input type="checkbox"/> BACK PAIN	<input type="checkbox"/> FREQUENT URINATION
<input type="checkbox"/> TROUBLE WITH URINATION	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> STOMACH/ABDOMINAL PAIN
<input type="checkbox"/> TROUBLE WITH VISION	<input type="checkbox"/> RASHES	<input type="checkbox"/> DIFFICULTY HEARING
<input type="checkbox"/> COUGHING UP BLOOD	<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> PHLEBITIS/BLOOD CLOTS
<input type="checkbox"/> SHORTNESS OF BREATH		<input type="checkbox"/> NUMBNESS IN ARMS OR LEGS
<input type="checkbox"/> IRREGULAR HEARTBEAT (PALPITATIONS)		

**FAMILY HISTORY**     NONE APPLY    **(CHECK ANY THAT APPLY)**

<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> DIABETES
<input type="checkbox"/> RHEUMATOID ARTHRITIS	<input type="checkbox"/> HEART PROBLEMS	<input type="checkbox"/> CANCER
<input type="checkbox"/> BLEEDING PROBLEMS	<input type="checkbox"/> OSTEOARTHRITIS	<input type="checkbox"/> STROKES