PATIENT QUESTIONNAIRE

NAME:________________________ DOB:____________ TODAY'S DATE:____________

OCCUPATION: ____________________ HEIGHT:______ WEIGHT:_____ DOMINANT HAND: ___R ___L

CHIEF COMPLAINT:________________________ DATE OF INJURY:______________

AFFECTED SIDE? R or L DESCRIBE PROBLEM:______________________________

INJURY OCCURED:____________ MAKES INJ. BETTER:____________ MAKES INJ. WORSE:____________

PAST MEDICAL HISTORY (CHECK ANY THAT APPLY TO YOU) ___ NONE APPLY

___ANEMIA
___ANXIETY
___ASBESTOSIS
___ASTHMA
___BIPOLAR DISORDER
___BLEEDING DISORDER
___BLOOD CLOT
___BRONCHITIS
___CANCER
___CA BRAIN
___CA BREAST
___CA CERVICAL
___CA COLON
___CA KIDNEY
___CA LUNG
___CA OVARIAN
___CA PROSTATE
___CA THYROID
___CHEST PAIN
___CHRONIC BACK PAIN
___COR. ARTERY DISEASE
___CON. HEART FAILURE
___DEPRESSION
___DIABETES
___EMPHYSEMA
___HEART ATTACK
___HEART MURMUR
___HYPERTENSION
___HEART STENT
___HEPATITIS A B C
___IRREGULAR HEARTBEAT
___HIATAL HERNIA
___HIGH CHOLESTEROL
___HIV
___HYPERTHYROIDISM
___HYPOTHYROIDISM
___KIDNEY STONES
___LIVER PROBLEMS
___LUNG PROBLEMS
___LUPUS
___MIGRAINES
___OTHER______________________
___ NEUROLOGICAL DISORDER
___ NUMBNESS/TINGLING
___ OSTEOARTHRITIS
___ PNEUMONIA
___ POOR CIRCULATION
___ PULMONARY EMBOLISM
___ REFLUX
___ RHEUMATOID ARTHRITIS
___ SEIZURE
___ SLEEP APNEA
___ STROKE
___ TUBERCULOSIS
___ UTI

PAST SURGICAL HISTORY (CHECK ANY THAT APPLY TO YOU) ___ NONE APPLY

___ABDOMINAL SURGERY
___AMPUTATION
___ANGIOPLASTY
___APPENDECTOMY
___ARTHROSCOPY KNEE
___ARTHROSCOPY SHOULDER
___BRONCHOSCOPY
___CABG
___CAROTID ENDARTERECTOMY
___COLON RESECTION
___FEMORAL BYPASS
___FRACTURE REPAIR
___GALLBLADDER REMOVAL
___GASTRIC BYPASS/BANDING
___HEART SURGERY
___HEMORRHOIDECTOMY
___HIP REPLACEMENT
___HYSTERECTOMY COMPLETE
___HYSTERECTOMY PARTIAL
___INTERVENTIONAL PAIN PROCEDURES
___KNEE REPLACEMENT
___KYPHOPLASTY
___NEPHRECTOMY
___PACEMAKER
___PARATHYROIDECTOMY
___PNEUMONECTOMY
___PROSTATECTOMY
___ROTATOR CUFF REPAIR
___SPINE SURGERY CERVICAL
___SPINE SURGERY THORACIC
___SPINE SURGERY LUMBAR
___TONSILLECTOMY
___T U R P
___VASECTOMY
___VERTEBROPLASTY
___OTHER______________________

FAMILY HISTORY ___ (CHECK ANY THAT APPLY) ___NONE APPLY

___ANESTHESIA PROBLEMS
___OSTEOPOROSIS
___STROKE
___CA CERVICAL
___CA OVARIAN
___OTHER______________________
___BLEEDING DISORDER
___ARTHRITIS
___TUBERCULOSIS
___CA COLON/RECTAL
___CA PROSTATE
___ASTHMA
___HYPERTENSION (MOM)
___CANCER
___CA BRAIN
___CA KIDNEY
___DIABETES
___HYPERTENSION (DAD)
___CA BREAST
___CA LUNG
___CA THYROID

SOCIAL HISTORY (CHECK ALL THAT APPLY TO YOU) ___NONE APPLY

___SINGLE
___MARRIED
___DIVORCED
___WIDOWED
___CIGARETTE SMOKING
___PIPE SMOKING
___CHEWING TOBACCO
___ALCOHOL
___PHYSICAL WORK
___SEDENTARY WORK
___RETIRED
___HOMEMAKER
___STUDENT
___REGULAR DUTY
___LIGHT DUTY
___OUT OF WORK

MEDICATIONS TAKEN DAILY (NAME AND DOSAGE) ___NONE

____________ ____________ ____________
____________ ____________ ____________
____________ ____________ ____________

PHARMACY USED: ______________________ PH#______________

ALLERGIES TO MEDICINE: (LIST ALL) ___ NO ALLERGIES

____
____

WAS THIS RELATED TO AN AUTOMOBILE ACCIDENT? __ Y __ N

REVIEW OF SYSTEMS

(Please circle YES or NO if any currently apply to you)

PRINT PATIENT NAME:______________________ PATIENT DOB: ____________ DATE: ____________

Have you had any new symptoms? Yes No

GENERAL:

Fever?	Yes	No
Chills?	Yes	No
Sweats?	Yes	No
Weakness?	Yes	No
Malaise?(discomfort)	Yes	No
Abnormal Weight Loss?	Yes	No
Sleep Disturbance?	Yes	No

EYES, EARS, NOSE, THROAT:

Double Vision?	Yes	No
Blurred Vision?	Yes	No
Eye Irritation?	Yes	No
Eye Discharge?	Yes	No
Vision Loss?	Yes	No
Eye Pain?	Yes	No
Light Sensitivity?	Yes	No
Earache?	Yes	No
Ringing in Ears?	Yes	No
Nasal Congestion?	Yes	No
Nosebleeds?	Yes	No
Sore Throat?	Yes	No
Difficulty Swallowing?	Yes	No
Hearing Loss?	Yes	No

CARDIAC:

Chest Discomfort?	Yes	No
Chest Pains?	Yes	No
Palpitations?	Yes	No
Syncope?(fainting)	Yes	No
Shortness of Breath?	Yes	No
Numbness in Arms?	Yes	No
Swelling of Limbs?	Yes	No

RESPIRATORY:

Cough?	Yes	No
Shortness of Breath?	Yes	No
Wheezing?	Yes	No
Chest Congestion?	Yes	No

GASTROINTESTINAL:

Nausea?	Yes	No
Vomiting?	Yes	No
Diarrhea?	Yes	No
Constipation?	Yes	No
Abdominal Pain?	Yes	No
Blood in Stool?	Yes	No
Heartburn?	Yes	No

GENITOURINARY:

Painful Urination?	Yes	No
Blood in Urine?	Yes	No
Urinary Frequency?	Yes	No
Urinary Hesitancy?	Yes	No
Incontinence?	Yes	No

MUSCULOSKELETAL:

Back Pain?	Yes	No
Joint Pain?	Yes	No
Joint Swelling?	Yes	No
Muscle Soreness?	Yes	No
Arthritis?	Yes	No

Do you have diabetes? Yes No

SKIN:

Sensation Disturbance?	Yes	No
Bruising?	Yes	No
Birthmark?	Yes	No
Rash?	Yes	No
Itching?	Yes	No
Dryness?	Yes	No
Suspicious Lesions?	Yes	No

NEUROLOGICAL:

Headaches?	Yes	No
Memory Loss?	Yes	No
Confusion?	Yes	No
Transient Paralysis?	Yes	No
Weakness?	Yes	No
Numbness?	Yes	No
Tingling?	Yes	No
History of Seizures?	Yes	No
Syncope?(fainting)	Yes	No
Tremors?	Yes	No
Vertigo?(dizzy)	Yes	No

PSYCHIATRIC:

Depression?	Yes	No
Anxiety?	Yes	No
Memory Loss?	Yes	No
Mental Disturbance?	Yes	No
Suicidal Thoughts?	Yes	No
Mood Disorders?	Yes	No
Paranoia?	Yes	No
Sleep Disturbances?	Yes	No
Eating Disorder?	Yes	No

ENDOCRINE:

Sensitivity to Cold?	Yes	No
Sensitivity to Heat?	Yes	No
Abnormal Weight Gain?	Yes	No
Excessive Thirst?	Yes	No
Excessive Urination?	Yes	No
Excessive Hunger?	Yes	No
Diabetes?	Yes	No

HEMATOLOGIC / LYMPHATIC:

Chronic Infections?	Yes	No
Abnormal Bruising?	Yes	No
Bleeding?	Yes	No
Enlarged Lymph Nodes	Yes	No

ALLERGIC / IMMUNOLOGIC:

Hives?	Yes	No
Hay Fever?	Yes	No
Persistent Infections?	Yes	No
HIV Exposure?	Yes	No
Runny Nose?	Yes	No
Sinus Congestion?	Yes	No

EXTREMITIES:

Redness of a limb?	Yes	No
Swelling of a limb?	Yes	No
Discoloration of a limb?	Yes	No