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HEALTH HISTORY QUESTIONNAIRE

Patient Name: Today's Date: Date of Birth:

Who referred you to our office?

Name of your Primary Care Physician:

Please list an emergency contact:

Relationship: Phone: ( )

I. Medical History (Problems), Surgery History, and Hospitalizations

Please list all medical history (problems), surgery history, and hospitalizations

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to any medications? ☐ Yes ☐ No If yes, which one(s):

Do you have any other known allergies? ☐ Yes ☐ No If yes, list here:

Your preferred pharmacy:

Pharmacy Name:

Pharmacy Location & Phone number:

II. *CURRENT COMPLAINTS*

What is the reason for your visit today (state body part)?

Please rate your pain on a scale of 1 to 10 (10 being the most painful): At rest:
At its worst:

Is the pain: ☐Worsening ☐Stable ☐ Improving ☐Constant ☐Occasional ☐Sharp
☐Dull ☐Aching ☐Stabbing ☐Throbbing

What symptoms are you experiencing? ☐Locking ☐Catching ☐Giving Way ☐Popping ☐Grinding
☐Bruising ☐Numbness ☐Tingling ☐Other (describe): _____

What, if anything, makes your symptoms **better**? ☐Rest ☐Activity ☐ Cold Therapy ☐Heat Therapy
☐Medication ☐Other (describe):

What, if anything makes your symptoms **worse**? ☐Inactivity ☐Exercise (describe) _____
☐Other (describe):

What treatments have you tried? ☐Nothing ☐Physical Therapy ☐Exercise ☐Acupuncture
☐Chiropractic ☐Bracing ☐Injections (i.e.: Synvisc, Hyalgan) ☐Ice ☐Decreased activity
☐ Medications ☐Other

III. *MEDICAL HISTORY*

Are you presently under a doctor's care for any other condition? ☐Yes ☐No If **yes**, please mark table below:

Please review and check if any of the following apply:

Disease	Personal History	Family History	Disease	Personal History	Family History
Asthma/Bronchitis	☐	☐	High Cholesterol	☐	☐
Bone/Joint Disease	☐	☐	High Blood Pressure	☐	☐
Psychiatric Illness (specify): _____	☐	☐	Deep Vein Thrombosis (DVT)	☐	☐
Chest Pain/Angina	☐	☐	Pulmonary Embolism (PE)	☐	☐
Cancer	☐	☐	Irregular Heart Beat	☐	☐
Kidney Disease	☐	☐	Osteoarthritis	☐	☐
Digestive Problems	☐	☐	Osteoporosis	☐	☐
Stomach Ulcer	☐	☐	Diabetes	☐	☐
Drug dependency	☐	☐	Gout	☐	☐
Epilepsy/Seizures	☐	☐	Liver Disease	☐	☐
Thyroid Disease	☐	☐	Nerves	☐	☐
Hay Fever	☐	☐	Numbness	☐	☐
Headaches/Migraine	☐	☐	Genetic Disease/Syndrome	☐	☐
Heart Disease	☐	☐	Poor Circulation	☐	☐
Anemia	☐	☐	Rheumatoid Arthritis	☐	☐
Bleeding Tendency	☐	☐	Stroke	☐	☐
Hemophilia	☐	☐	TB/Tuberculosis	☐	☐
Hepatitis	☐	☐	AIDS/HIV	☐	☐
Alcohol dependency	☐	☐	**OTHER**:	☐	☐

Please mark any other problems which you may also be experiencing at the present time:

Musculoskeletal	**Neurological**	**General**	**Respiratory**
☐ Joint pain	☐ Paralysis	☐ Weight loss	☐ Wheezing
☐ Stiffness	☐ Tremors/Shakiness	☐ Weight gain	☐ Coughing
☐ Fractures	☐ Gait disturbances	☐ Fevers	☐ Pain in breathing
☐ Joint Swelling	☐ Other	☐ Chills	☐ Blood clots
☐ Muscle weakness		☐ Other	☐ Other
☐ Other			
Skin	**Head**	**Eyes**	**Ear, Nose, Throat**
☐ Rashes, itching	☐ Headaches	☐ Changes in vision	☐ Hearing loss
☐ Ulcers/sores	☐ Seizures	☐ Photophobia	☐ Vertigo
☐ Bruising	☐ Loss of consciousness	☐ Pain/redness	☐ Nosebleed
☐ Bleeding tendencies	☐ Other	☐ Excessive tearing	☐ Snoring
☐ Other		☐ Other	☐ Tinnitus
			☐ Other
Genitourinary	**Cardiovascular**	**Gastrointestinal**	**Other (please list below)**
☐ Loss of bladder control	☐ Chest pains	☐ Difficulty with swallowing	
☐ Urinary frequency	☐ Shortness of breath	☐ Heartburn	
☐ Other	☐ Palpitations	☐ Nausea/Vomiting	
	☐ Other	☐ Blood in bowel	
		☐ Other	

Medical History ***(continued)***
Surgeries: Include type of surgery and when surgery was performed:
Hospitalizations. Please list any dates of hospitalizations and reasons:
Are you pregnant or could become pregnant? ☐Yes ☐No
Do you have a history of fracture(s)? ☐Yes ☐No If yes, list here:
IV. *SOCIAL HISTORY*
Exercise: ☐Sedentary (No exercise) ☐Mild (i.e. climbing stairs, walk 3 blocks, golf) ☐Occasional, vigorous (less than 4 times a week for 30 minutes) ☐Regular Vigorous (4+ times a week, 30+ minutes)
Caffeine: Please indicate amount of cups consumed daily for each. ☐None ____ Coffee ____Tea ____Soda
Do you smoke? ☐Yes ☐No If yes, amount per day:
Do you drink alcohol? ☐Yes ☐No If yes, how much: How often:
Illicit drugs: Do you currently use any type of recreational/street drugs? ☐Yes ☐No If yes, please indicate type of product used and how much used on a daily basis: Have you ever been admitted into a drug rehabilitation program? ☐Yes ☐No If yes, please indicate when you attended:
Marital Status: ☐Single ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed
Do you have any children? ☐Yes ☐No If yes, how many?
Do you have any hobbies or any recreational activities that you enjoy participating in on a regular basis? ☐Yes ☐No If yes, please list.
What is your primary language?
Do you speak any other languages? ☐Yes ☐No If yes, please list.
What state or country were you born in?
Right or left hand dominant?
What is your current occupation?
Height: Weight:
Patient Signature: Date:
Printed Name:

Physician Signature_____**Date**_____