



MEDICAL QUESTIONNAIRE

GENERAL

Patient Name Last Name First Name M.I. Gender (Circle / Check) Today's Date (MM/DD/YY)
Male Female
Social Security # Height Weight Age Which is your dominant hand? (Circle/Check)
Right Left
Referring Physician Name Primary Care Physician (PCP)

CURRENT INJURY

What part of your body is injured? Which side is injured? (Circle/Check)
Right Left
How did your problem develop: over time or was it an injury?
What is the date (MM/DD/YY) and place of the injury?
Describe how the injury happened?
What are your current symptoms?
How do these symptoms limit your ability to perform work duties?
Do your symptoms affect your activities of daily living? If so, explain.
Do you have any numbness and/or tingling? If so, where?
Do your symptoms keep you awake at night? If so, explain.
Have you noticed any weakness? If so, explain.
Describe any treatment you have used for the current injury.
How has the treatment helped?
Describe your current walking tolerance. I can walk up to street blocks.
Do you use any walking devices? If yes, what type?
Describe how you walk up stairs. (Circle/Check)
Place one foot per step Place both feet on step before proceeding to next Not Applicable; Don't use stairs

MEDICAL AND SURGICAL HISTORY

List all medical problems you have:
List all medications you are taking:
List all herbal, naturopathic and homeopathic medications/supplements you are taking:
List all surgeries you have had:
List all drug allergies (include name of medication and reaction):

SOCIAL HISTORY

What is your marital status? (Circle/Check) Single Married Domestic Partner Divorced / Widowed Name:
What are your hobbies / interests?
Do you drink alcohol? (Circle/Check) Never Rarely Socially Daily
Do you use tobacco products? (Circle/Check) No Yes If yes, how many packs per day?

I hereby authorize examination and whatever services deemed necessary. I agree to assume financial responsibility for ALL services provided.

X

Patient Signature

Date

TURN PAGE

# MEDICAL QUESTIONNAIRE

## HEALTH REVIEW (Do you have any of the following?)

<b>GENERAL</b>			<b>GASTROINTESTINAL</b>		
Have you been in good general health most of your life	No	Yes	Vomiting blood or food	No	Yes
Any allergies, including medication	No	Yes	Gallbladder disease	No	Yes
Any recent weight gain	No	Yes	Liver trouble	No	Yes
<b>SKIN</b>			Hepatitis	No	Yes
Skin Disease	No	Yes	Painful bowel movements	No	Yes
Jaundice	No	Yes	Black stools	No	Yes
Hives, eczema or rash	No	Yes	Hemorrhoids or piles	No	Yes
Frequent infections or boils	No	Yes	Recent changes in bowel habits	No	Yes
Abnormal pigmentation	No	Yes	Frequent diarrhea	No	Yes
<b>HEAD, EYES, EARS, NOSE, THROAT</b>			Heartburn or indigestion	No	Yes
Eye diseases or injury	No	Yes	<b>GENITOURINARY</b>		
Wear glasses	No	Yes	Loss of urine	No	Yes
Double vision	No	Yes	Frequent urination	No	Yes
Headaches	No	Yes	Night time urinating	No	Yes
Glaucoma	No	Yes	Blood in urine	No	Yes
Itching eyes or nose	No	Yes	Kidney trouble	No	Yes
Sneezing or runny nose	No	Yes	Kidney stones	No	Yes
Nosebleeds	No	Yes	<b>LOCOMOTOR - MUSCULOSKELETAL</b>		
Chronic sinus trouble	No	Yes	Varicose veins	No	Yes
Ear disease	No	Yes	Weakness of muscles or joints	No	Yes
Impaired hearing	No	Yes	Difficulty walking	No	Yes
Dizziness or transient episodes of unconsciousness	No	Yes	Pain in calves or buttocks on walking, relieved by rest	No	Yes
<b>RESPIRATORY</b>			<b>NEURO - PSYCHIATRIC</b>		
URI (cold) now	No	Yes	Ever had psychiatric care	No	Yes
Spitting up blood	No	Yes	Ever been advised to see a psychiatrist	No	Yes
Chronic of frequent cough	No	Yes	Fainting spells	No	Yes
Asthma or wheezing	No	Yes	Convulsions	No	Yes
Difficulty breathing	No	Yes	Paralysis	No	Yes
<b>CARDIOVASCULAR</b>			<b>ENDOCRINE</b>		
Chest pain or angina pectoris	No	Yes	Thyroid disease	No	Yes
Shortness of breath with walking or lying down	No	Yes	Hormone therapy	No	Yes
Heart trouble or heart attacks	No	Yes	Any change in hat or glove size	No	Yes
High blood pressure	No	Yes	Any change in hair growth	No	Yes
Swelling of hands, feet or ankles	No	Yes	Become colder than before or skin become dryer	No	Yes
Heart murmur	No	Yes	<b>HEMATOLOGICAL</b>		
<b>NECK</b>			Slow to heal after cuts	No	Yes
Stiffness	No	Yes	Blood disease	No	Yes
Thyroid trouble	No	Yes	Anemia	No	Yes
Enlarged Glands	No	Yes	Phlebitis	No	Yes
			Bleeding excessively after tooth extraction or surgery	No	Yes

## FAMILY'S HEALTH REVIEW (Has any blood relative ever had any of the following?)

Cancer	No	Yes	Convulsions	No	Yes
Tuberculosis	No	Yes	Suicide	No	Yes
Diabetes	No	Yes	Mental illness	No	Yes
Heart trouble	No	Yes	Bleeding tendency	No	Yes
High blood pressure	No	Yes	Gout or other arthritis	No	Yes
Stroke	No	Yes	Hereditary defects	No	Yes

ALL OF THE ABOVE INFORMATION IS TRUE

**X**

**X**

PERSON ACQUIRING / WRITING THIS INFORMATION (IF OTHER THAN PATIENT)

RELATIONSHIP TO PATIENT

**X**

**X**