Medical History Questionnaire

DATE: _____

Name: _____ Age: _____ ☐ Right-Handed ☐ Left Handed

Referring Physician: _____ Primary Care Physician (PCP): _____

Preferred Pharmacy: _____ Phone: _____

Pharmacy Address: _____ City: _____

REASON FOR VISIT? _____ **NEW PROBLEM** ☐ Yes ☐ No.

MEDICATION HISTORY- **Please list all current medication (including over the counter medications)** ***Please feel free to attach additional sheets if necessary.***

Medication	Indication	Dose	Prescribing Physician

Pain Analogue Scale:

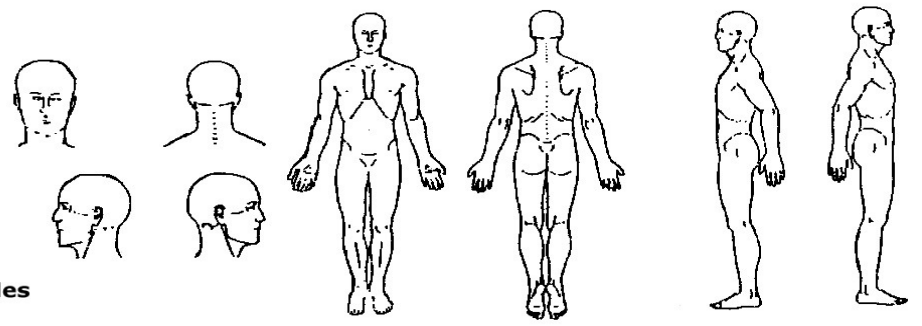
No Pain	*Minimal*	*Moderate*	*Intense*	*Emergency*
0	*1 2 3*	*4 5 6*	*7 8 9*	*10*

Please rate your pain: Today: ____ /10 Average day: ____ /10 Good Day: ____ /10 Bad Day ____ /10

Pain Diagram:

- Please mark the areas of your pain. You may use the key to indicate different kinds of pain sensations.
- Please number each painful area in order of the

Key:
- → - shooting
- /// - stabbing
- xxx - aching
- 000 - throbbing
- ●●● - pins & needles
- *** - burning



REVIEW OF SYSTEMS

CONSTITUTIONAL ☐ Fever ☐ Weight Loss ☐ Weight Gain ☐ Weakness ☐ Fatigue ☐ Difficulty Sleeping ☐ Chills ☐ Night Sweats

EYES ☐ Visual Problems ☐ Glaucoma

HENT ☐ Headaches ☐ Sinus Problmes ☐ Hearing Problems ☐ Sleep Apnea

CARDIOVASCULAR ☐ Heart Trouble ☐ Swelling of feet ☐ Hypertension ☐ Lower Extremity Swelling

RESPIRATORY ☐ Cough ☐ Shortness of Breath

GASTROINTESTINAL ☐ Liver Disease ☐ Hepatitis ☐ Gall Bladder Problems ☐ Reflux ☐ Bowel Problems ☐ Consitpation ☐ Diarrhea

GENITOURINARY ☐ Kidney Stone ☐ Kidney Disease ☐ Bladder Problems ☐ Blood in Urine ☐ Reduced Libido (desire for sex)

INTEGUMENT ☐ Dry Skin ☐ Rashes

NEUROLOGICAL ☐ Seizures ☐ Stroke ☐ Peripheral neuropathy ☐ Numbness ☐ Memory or concentration difficulties
☐ Loss of Balance ☐ Falls ☐ Head Injuries

MUSCULOSKELETAL ☐ Neck Pain ☐ Shoulder Pain ☐ Elbow Pain ☐ Wrist/Hand Pain ☐ Carpal Tunnel Syndrome
☐ Low Back Pain ☐ Hip Pain ☐ Knee Pain ☐ Foot/Ankle Pain ☐ Gout

ENDOCRINE ☐ Thyrod Problem ☐ Diabetes ☐ Excessive Thirst

PSYCHIATRIC ☐ Depression ☐ Anxiety ☐ Anger ☐ Guilt

HEME-LYMPH ☐ Easy Bruising ☐ HIV Exposure ☐ Bleeding Problems

ALLERGIC-IMMUNOLOGIC ☐ Seasonal Allergy Allergies ☐ Anaphylactic (Severe) Medication Allergies ☐ Anaphylactic (severe) Reaction to Bee Stings

ALLERGIES

☐ **NO KNOWN DRUG ALLERGIES** ☐ Iodine ☐ Contrast Dye (IVP) ☐ Latex

Please list drug allergies, type or reaction and onset date, if known: _____

Any severe allergic Reactions (Anaphylaxis) to anything? ☐ Yes ☐ No If yes, to what, type of reaction and onset date:

_____

_____

PAST MEDICAL HISTORY

☐ **No significant Past Medical History**
☐ Alzheimer's disease/Dementia
☐ Anxiety
☐ Asthma/COPD
☐ Atrial fibrillation
☐ CANCER-Type: _____
☐ Cardiac pacemaker
☐ Chronic Regional Pain Syndrome (CRPS)
☐ Depression
☐ DVT (blood clot)
☐ Ehler's Danlos Syndrome
☐ Gastric ulcer
☐ Glaucoma
☐ Head Injury or Concussion
☐ Heart Disease (Coronary Artery Disease)
☐ Heart Failure
☐ Hernia
☐ High Cholesterol
☐ HIV/Aids Disease
☐ Hypertension (High Blood Pressure)
☐ Irritable Bowel Syndrome
☐ Kidney Disease
☐ Lupus
☐ Lyme Disease
☐ Marfan Syndrome
☐ Migraines
☐ Osteoporosis
☐ Parkinson's Disease
☐ Peripheral Neuropathy
☐ Peripheral Vascular Disease
☐ Rheumatoid arthritis
☐ Seizure disorder
☐ Shingles
☐ Sleep Apnea
☐ Stroke (CVA)
☐ Other Past Medical History: _____

SURGICAL HISTORY

☐ **No Pertinent Past Surgical History**

Please list all surgeries: _____

_____

_____

FAMILY MEDICAL HISTORY

☐ **No Significant Family History** ☐ **Family History Unknown**

Condition:	Relative	Age	Condition	Relative	Age
☐ Cancer: TYPE: _____			☐ High blood pressure (Hypertension)		
☐ Diabetes			☐ Stroke		
☐ Heart disease (coronary artery disease)					

☐ **Other Family Medical Problems:** _____

_____

SOCIAL HISTORY

☐ Able to care for self
☐ Able to drive
☐ Climbs stairs daily
☐ Regular exercise

Alcohol:
☐ Denies use ☐ Occasional use
☐ more than 15 drinks/week

Marital status:
☐ Single ☐ Married
☐ Divorced/separated ☐ Widow/Widower

Smoking: ☐ Denies
☐ Admits to smoking (____ packs/day) ☐ Former Smoker: Date Quit: _____

Substance Abuse : ☐ Denies
☐ In past (including alcohol)
☐ Use of illegal drugs in the last year

Work status:
☐ Student
☐ Does not work outside the home: ☐ Disabled ☐ Retired
☐ Works outside the home

Occupation: _____

Other important social issues: _____

_____