

How often do you have the pain? constantly hourly daily weekly

What makes it better? rest heat cold elevation physical therapy braces injections medications
 other _____

What makes the pain worse? _____

Is this the first time you have had problem with this area? no yes Describe prior problem: _____

For this problem have you had any of these tests: X-Ray MRI CT scan ultrasound bone scan EMG
 nerve study If so, where? _____

Did you bring them with you? yes no

Prior Treatment:

oral medication medicines: _____ braces type: _____ heat
 injection how many: _____ physical therapy for how long: _____ cold
 chiropractor where: _____ elevation
 cane crutch walker wheelchair other _____

Previous Treating Physician: _____

Has a physician recommended that you have surgery for this problem? yes no

Past Medical History: Have you or any family member had any of the following medical problems?

<u>You</u>	<u>Family</u>	<u>You</u>	<u>Family</u>	<u>You</u>	<u>Family</u>	<u>You</u>	<u>Family</u>
<input type="checkbox"/>	<input type="checkbox"/> kidney stones	<input type="checkbox"/>	<input type="checkbox"/> cancer	<input type="checkbox"/>	<input type="checkbox"/> high blood pressure	<input type="checkbox"/>	<input type="checkbox"/> arthritis
<input type="checkbox"/>	<input type="checkbox"/> endocrine disorders	<input type="checkbox"/>	<input type="checkbox"/> anemia	<input type="checkbox"/>	<input type="checkbox"/> high cholesterol	<input type="checkbox"/>	<input type="checkbox"/> rheumatoid
<input type="checkbox"/>	<input type="checkbox"/> diabetes	<input type="checkbox"/>	<input type="checkbox"/> bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/> stroke	<input type="checkbox"/>	<input type="checkbox"/> osteoarthritis
<input type="checkbox"/>	<input type="checkbox"/> asthma	<input type="checkbox"/>	<input type="checkbox"/> blood clots /pulmonary embolism	<input type="checkbox"/>	<input type="checkbox"/> nervous disorder	<input type="checkbox"/>	<input type="checkbox"/> osteopenia
<input type="checkbox"/>	<input type="checkbox"/> emphysema	<input type="checkbox"/>	<input type="checkbox"/> phlebitis	<input type="checkbox"/>	<input type="checkbox"/> depression	<input type="checkbox"/>	<input type="checkbox"/> osteoporosis
<input type="checkbox"/>	<input type="checkbox"/> tuberculosis	<input type="checkbox"/>	<input type="checkbox"/> atrial fibrillation/irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/> balance problems
<input type="checkbox"/>	<input type="checkbox"/> ulcers	<input type="checkbox"/>	<input type="checkbox"/> heart trouble/disease	<input type="checkbox"/>	<input type="checkbox"/> hepatitis	<input type="checkbox"/>	<input type="checkbox"/> sleep apnea
<input type="checkbox"/>	<input type="checkbox"/> colitis			<input type="checkbox"/>	<input type="checkbox"/> lyme disease		
<input type="checkbox"/>	<input type="checkbox"/> reflux						
<input type="checkbox"/>	none of the above	<input type="checkbox"/>	others _____				

Family Medical History: If your parents, grandparents, siblings, or children have any of the medical problems listed above, please explain:

Are you pregnant? yes no Breast feeding? yes no



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Have you (or are you) receiving all the standard child immunizations? yes no If no, please explain: _____

Have you ever received a tetanus shot? no yes If yes, please provide approximate date of last tetanus shot: ____/____/____

Have you had a prior blood transfusion? no yes If yes, when? _____

Have you ever had problems with anesthesia? no yes If yes, what problems? _____

Past Surgical History:

Type of surgery: _____ year _____ Type of surgery _____ year _____

Type of surgery: _____ year _____ Type of surgery _____ year _____

Type of surgery: _____ year _____ Type of surgery _____ year _____

Prescription / Nonprescription Medications: (including herbal supplements and vitamins)

Name:	Dose:	Taken per day:	Name:	Dose:	Taken per day:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Allergies:

none codeine/pain medications shellfish Novocain metal/jewelry aspirin

penicillin/antibiotics iodine local anesthetics latex food _____

sulfa contrast lidocaine others _____

Type of reaction: _____

Social History:

Occupation _____ Working now? yes no retired disabled

Do you use tobacco? packs per day: ____ quit if quit, years smoked: ____ Pipe? yes no Smokeless? yes no

Alcohol use: never occasional daily heavy History of alcoholism? yes no History of drug use? yes no

Marital status: single married divorced widowed

Do you live alone? yes no If no, who do you live with? _____

Type(s) of exercise/sports activity: _____ How often? _____ per week

Review of Systems: are you currently having problems with any of the following:

Genitourinary

- blood in urine
- kidney stones
- Frequency
- sexual problems
- retention
- testicle pain
- menstrual problems
- foul odor/cloudiness

Skin

- rash/itching/psoriasis
- breast lump
- hair change
- nail change

Eyes

- wear glasses/contacts
- blurred vision
- eye disease
- glaucoma

Constitutional

- weight change
- fever
- chills
- fatigue

Gastrointestinal

- nausea/vomit
- stomach pain
- rectal bleeding
- bowel problem/colitis

Musculoskeletal

- pain/cramps
- joint swelling
- joint pain
- trouble walking

Endocrine

- excessive urination
- thyroid disease
- hormone problem

Respiratory

- short of breath
- cough
- wheezing
- bronchitis

Hematologic

- bruise easily
- slow to heal
- enlarged glands

Neurological

- headaches
- tremors
- seizures
- numbness
- weakness

Ears/Nose/Mouth/Throat

- hearing loss/ringing
- sinus problems
- nose bleeds
- sore throat

Cardiovascular

- chest pain
- palpitations
- heart trouble
- swelling

Psychiatric

- insomnia
- confusion
- depression

Patient/Guardian Statement:

To the best of my knowledge, the above information is accurate and complete.

_____/_____/_____
Signed Date

_____/_____/_____
Medical Professional Signature Date

Provider Statement:

I have reviewed the questionnaire with the patient.

_____/_____/_____
Signed Date

_____/_____/_____
Signed Date

_____/_____/_____
Signed Date

_____/_____/_____
Signed Date

Signed _____ Date ____/____/____