PATIENT HISTORY & PHYSICAL MEDICAL QUESTIONAIRE

Patient Name: _____ **DOB:** _____ **Age:** _____

Social Security #: _____

CHIEF COMPLAINT

Please describe your problem (include date of injury if applicable): _____

_____.

REVIEW OF CURRENT SYSTEMS (Please check all that apply)

Respiratory

_____ - Cough
_____ - Short of Breath
_____ - Wheezing

Cardiovascular

_____ - Chest Pain
_____ - Palpitations
_____ - Swelling of Legs

Gastrointestinal

_____ - Abdominal Pain
_____ - Change in Bowl Habits
_____ - Heartburn

Musculoskeletal

_____ - Back Problems
_____ - Deformities
_____ - Joint Pain
_____ - Joint Stiffness
_____ - Muscle Cramps
_____ - Muscle Stiffness
_____ - Restricted Motion
_____ - Weakness

Psychiatric

_____ - Behavioral Change
_____ - Memory Loss

Neurological

_____ - Neuropathy

Endocrine

_____ - Change in Hair/Skin
_____ - Heat/Cold Intolerance

PATIENT PAST MEDICAL HISTORY (Please check all that apply)

____ - ADHD/ADD
____ - Alcohol Dependent
____ - Alzheimer's
____ - Anemia
____ - Anxiety
____ - Arthritis
____ - Asthma
____ - BPH
____ - Back Problems
____ - Benign Prostatic Hyp.
____ - Bipolar
____ - Blind
____ - Blood Clots
____ - Breast Cancer
____ - Bronchitis
____ - CAD
____ - CHF
____ - COPD
____ - Cancer What kind? _____
____ - High Cholesterol
____ - Crohn's Disease
____ - Deaf
____ - Dementia
____ - Depression
____ - Diabetes
____ - Diag. Poor Circulation
____ - Drug Dependent
____ - Emphysema
____ - Epilepsy
____ - Fibromyalgia
____ - GERD
____ - Glaucoma
____ - Gout
____ - HIV
____ - Hard of Hearing
____ - Heart Disease
____ - Hemorrhoids
____ - Hepatitis
____ - Hypertension/HBP
____ - Irritable Bowl Syn
____ - Liver Disease
____ - Lupus
____ - MI/Heart Attack
____ - Macular Degen.
____ - Migraine
____ - OCD
____ - Paralysis
____ - Pneumonia
____ - Psychiatric Disorder
____ - Renal Stone
____ - Schizophrenia
____ - Sickle Cell
____ - Sleep Apnea
____ - Stroke
____ - TB
____ - TIA/Mini Stroke
____ - Thyroid Disease
____ - Tuberculosis
____ - Ulcer (GI)

DRUG ALLERGIES

Please list any known Drug Allergies. _____

_____

MEDICATION

☐ No Medications to report.

List all current medications or provide a list to be copied. (It is MANDATORY that we have this for all new patients to be seen) _____

_____

_____

PREFERRED PHARMACY: _____ Location (Street/City/State): _____

FAMILY MEDICAL HISTORY

☐ No Family Medical History to report

Has any close blood relative had any of the following (Please indicate relationship) Example: Mother, Father, Brother, Sister
Please circle whether that relative is Alive (A) or Deceased (D).

Cancer: _____(A / D) Diabetes: _____(A / D) Heart Trouble: _____(A / D)

Stroke: _____(A / D) Arthritis: _____(A / D) Kidney Disease: _____(A / D)

Blood Clots: _____(A / D) Tuberculosis: _____(A / D) Emphysema: _____(A / D)

SOCIAL HISTORY

☐ No Social History to report

Tobacco

Cigarettes:	Former / Never / Current	____ packs per day	For how long? _____
Cigars:	Former / Never / Current	____ packs per day	For how long? _____
Pipe:	Former / Never / Current	____ packs per day	For how long? _____
Chewing Tobacco:	Former / Never / Current	____ packs per day	For how long? _____
Dipping Tobacco:	Former / Never / Current	____ packs per day	For how long? _____

Alcohol

Beer	Social / Occasional / Light / Heavy	How often? _____	For how long? _____
Wine	Social / Occasional / Light / Heavy	How often? _____	For how long? _____
Hard Liquor	Social / Occasional / Light / Heavy	How often? _____	For how long? _____

EMPLOYMENT HISTORY

Employer: _____

Occupation/Job Title: _____

Duration on Job: ____ - 0-6 months ____ - 6-12 months ____ - 1-5 years ____ - 5+ years

Required Footwear: ____ Steel Toe ____ - Non-Slip Sole ____ - Rubber Boot ____ - None

SURGICAL HISTORY

☐ No known surgeries to report

Please list all **major** surgeries with estimated dates and the Doctor who performed the surgery.

_____

_____

Patient Height: _____ Foot _____ Inches **Patient Weight**: _____ Lbs.

The information provided here is true to the best of my knowledge. I authorize release of any previous medical records including medication history by fax, mail or phone by either physician or hospital. Also, I hereby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition with x-ray, examination or photographs of infections as necessary.

X Patient Signature: _____ **Date:** _____