Patient History Questionnaire

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

Doctor(s) who referred you/Primary care:_____ Phone:_____

Reason for visit:_____ Date of Injury:_____

I. History of Present Illness (HPI)

Pain - Where?_____ Describe it (bum, stab, dull, etc.)_____

When does it occur?_____ How long does it last?_____

How long has it occurred?_____ How severe?_____

What makes it better or worse?_____

Numbness (tingling, asleep) - Where?_____ Describe it (bum, stab, dull, etc.)_____

When does it occur?_____ How long does it last?_____

How long has it occurred?_____ How severe?_____

What makes it better or worse?_____

Other Complaints: _____

II. Past Medical History *Please circle Yes or No if you have any of the following medical problems*

Diabetes	Yes	No	Stroke	Yes	No
Heart Disease	Yes	No	Blood Clots	Yes	No
High Blood Pressure	Yes	No	Kidney Disease	Yes	No
Breathing Problems	Yes	No	Liver Disease	Yes	No
Bleeding Problems	Yes	No	Cholesterol	Yes	No
Thyroid Disease	Yes	No	HIV	Yes	No
			Hepatitis	Yes	No

Others please list:_____

_____

PastSurgical History/Dates:_____

_____

_____

Medications (doses and how often you take them):_____

_____

_____

_____

Allergies: Yes No _____ Reactions:_____

_____

Height_____ Weight _____

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If necessary, can you receive blood or blood products? Yes No

Social History

Tobacco: Yes / No ____Pack per day for____years

Alcohol use: Yes / No How much?_____

Illicit Drug use:_____

Occupation/Hobbies:_____

Right or Left hand dominant_____Marital Status:_____lives with_____

Use Cane, Walker or Wheelchair_____

Family History *List medical problems of your relatives*

Father: _____ Mother: _____

Siblings:_____Others: _____

III. Review of Systems *Please circle Yes or No if you have any of the following medical problems*

Constitutional			**Ears/Nose/Mouth/Throat**			**Eyes**		
Good general health	Yes	No	Hearing loss or ringing	Yes	No	Wear glasses/contacts	Yes	No
Recent weight change	Yes	No	Sinus problems	Yes	No	Blurred/double vision	Yes	No
Night sweats/fevers	Yes	No	Nosebleeds	Yes	No	Eye disease or injury	Yes	No
Fatigue	Yes	No	Sore throat/voice change	Yes	No	Glaucoma	Yes	No
Cardiovascular			**Respiratory**			**Gastrointestinal**		
Chest pain	Yes	No	Shortness of breath	Yes	No	Nausea/vomiting	Yes	No
Palpitation	Yes	No	Cough	Yes	No	Abdominal pain	Yes	No
Heart trouble	Yes	No	Wheezing/Asthma	Yes	No	Rectal bleeding	Yes	No
Swelling hands/feet	Yes	No	Coughing up blood	Yes	No	Bowel problems	Yes	No
Muscukskeletal			**Neurological**			**Integumeniary (Skin)**		
Muscle pain or cramps	Yes	No	Frequent headaches	Yes	No	Change in hair or nails	Yes	No
Stiffness/swelling joints	Yes	No	Paralysis or tremors	Yes	No	Rashes or itching	Yes	No
Joint pain	Yes	No	Convulsions/seizures	Yes	No	Easily bruise	Yes	No
Trouble walking	Yes	No	Numbness tingling	Yes	No	Easily bleed	Yes	No
Endocrine			**Hematologic / Lymphatic**			**Allergic / Immunologic**		
Excessive thirst/urination	Yes	No	Bruise easily	Yes	No	Food allergies	Yes	No
Thyroid disease	Yes	No	Slow to heal	Yes	No	Aspirin allergies	Yes	No
Hormone problem	Yes	No	Enlarged glands	Yes	No	Antibiotic allergies	Yes	No
Genitourinary			**Psychiatric**					
Blood in urine	Yes	No	Insomnia	Yes	No	**Most Recent**	**Date**	
Kidney stones	Yes	No	Confusion/memory loss	Yes	No	Colonoscopy	____	____
Sexual problems	Yes	No	Depression	Yes	No	Mammogram	____	____
Testicle pain/ menstrual problems	Yes	No				Influenza/Flu Shot	____	____
						Pneumococcal/Pneumonia	____	____

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

Signed:_____Date:_____