

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ SS#: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

**HISTORY OF PRESENT ILLNESS**

Please explain your problem in one sentence: \_\_\_\_\_

Work related?  Yes  No

Where is your problem located?  Right  Left  Location \_\_\_\_\_

When did your problem start? \_\_\_\_\_

Severity of pain. Scale of 1-10 1 - Minimal 10 - Severe \_\_\_\_\_

What else do you experience?  Swelling  Grinding  Give way  Catching  Popping  Locking  Sleeping Problems

Does the condition affect ability to work?  Yes  No \_\_\_\_\_  Medical Leave  
How? \_\_\_\_\_ Occupation \_\_\_\_\_  Light Duty

Have you previously had this or a similar problem?  Yes  No

Did you improve? \_\_\_\_\_

Why? \_\_\_\_\_

What previous treatment for this problem have you had?  Surgery \_\_\_\_\_

PT/OT  Injections  Braces / Straps  Medicine \_\_\_\_\_

Casting  Chiropractor

Please list doctors who have treated you for this particular problem:

(Name)	(Specialty)	(City)	(Date)

Have you had:	When	Where	Study Here	Report Here
<input type="checkbox"/> X-Ray			<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> MRI			<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bone Scan			<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> CT			<input type="checkbox"/>	<input type="checkbox"/>

**PATIENT MEDICAL HISTORY**

Please circle Yes or No if you have any of the following medical problems.

High blood pressure	Yes	No	Diabetes	Yes	No	Heart Trouble	Yes	No
Respiratory Problems	Yes	No	Stroke	Yes	No	Cancer	Yes	No
Bleeding Problems	Yes	No	HIV / AIDS	Yes	No	Other Problems	_____	

Current Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Drug Allergies or Substance Allergies  Yes  No List: \_\_\_\_\_

Past Hospitalizations / Surgeries / Injuries and Approximate Dates  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family History:** Have any of your relatives (e.g.. - Mother, Father, Brother, Sister, Grandparent) ever had:

	Yes	No	Relationship
1. Heart Disease	_____	_____	_____
2. High Blood Pressure	_____	_____	_____
3. Diabetes	_____	_____	_____
4. Stroke	_____	_____	_____
5. Cancer (Location)	_____	_____	_____
6. Thyroid Disease	_____	_____	_____
7. Other Disease	_____	_____	_____

**Social History:** Marital Status:  Single  Married  Separated  Divorced  Widowed  
 Tobacco Use:  Never  Quit/ When \_\_\_\_\_  Current smoker / packs per day \_\_\_\_\_  
 Alcohol Use:  Never  Rarely  Moderate  Daily  How much? \_\_\_\_\_  
 Drug Use:  Never  Type & Frequency \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Other: \_\_\_\_\_

**REVIEW OF SYSTEMS (ROS)**

Please circle Yes or No if you have any of the following problems.

- |  |  |  |
|--|--|--|
| <p><input type="checkbox"/> <b>Constitutional</b></p> <p>Good General Health      Yes   No</p> <p>Recent Weight Change    Yes   No</p> <p>Night sweats, fevers      Yes   No</p> <p>Fatigue                      Yes   No</p>                        | <p><input type="checkbox"/> <b>Ears/Nose/Mouth/Throat</b></p> <p>Hearing loss or ringing    Yes   No</p> <p>Sinus Problems              Yes   No</p> <p>Nose Bleeds                 Yes   No</p> <p>Sore throat/voice change   Yes   No</p>        | <p><input type="checkbox"/> <b>Eyes</b></p> <p>Wear glasses/contacts    Yes   No</p> <p>Blurred/double vision      Yes   No</p> <p>Eye disease or injury      Yes   No</p> <p>Glaucoma                     Yes   No</p>                              |
| <p><input type="checkbox"/> <b>Cardiovascular</b></p> <p>Chest pain                  Yes   No</p> <p>Palpitations                 Yes   No</p> <p>Heart Trouble                Yes   No</p> <p>Swelling hands / feet      Yes   No</p>               | <p><input type="checkbox"/> <b>Respiratory</b></p> <p>Shortness of breath        Yes   No</p> <p>Cough                         Yes   No</p> <p>Wheezing / Asthma         Yes   No</p> <p>Coughing up blood         Yes   No</p>                    | <p><input type="checkbox"/> <b>Gastrointestinal</b></p> <p>Nausea / vomiting         Yes   No</p> <p>Abdominal pain              Yes   No</p> <p>Rectal Bleeding             Yes   No</p> <p>Bowel problems             Yes   No</p>                 |
| <p><input type="checkbox"/> <b>Musculoskeletal</b></p> <p>Muscle pain or cramps     Yes   No</p> <p>Stiffness/swelling joints   Yes   No</p> <p>Joint pain                    Yes   No</p> <p>Trouble walking             Yes   No</p>               | <p><input type="checkbox"/> <b>Neurological</b></p> <p>Frequent Headaches        Yes   No</p> <p>Paralysis or tremors        Yes   No</p> <p>Convulsions/seizures      Yes   No</p> <p>Numbness/tingling         Yes   No</p>                      | <p><input type="checkbox"/> <b>Integumentary (Skin / Breast)</b></p> <p>Change in hair or nails     Yes   No</p> <p>Rashes or itching            Yes   No</p> <p>Breast lump                 Yes   No</p> <p>Breast pain or discharge   Yes   No</p> |
| <p><input type="checkbox"/> <b>Endocrine</b></p> <p>Excessive thirst/urination   Yes   No</p> <p>Thyroid disease             Yes   No</p> <p>Hormone Problem            Yes   No</p>   | <p><input type="checkbox"/> <b>Hematologic / Lymphatic</b></p> <p>Bruise easily                Yes   No</p> <p>Slow to heal                 Yes   No</p> <p>Enlarged Glands             Yes   No</p>   | <p><input type="checkbox"/> <b>Allergic / Immunologic</b></p> <p>Food Allergies              Yes   No</p> <p>Aspirin Allergies            Yes   No</p> <p>Antibiotic Allergies        Yes   No</p>   |
| <p><input type="checkbox"/> <b>Genitourinary - Male Only</b></p> <p>Blood in urine               Yes   No</p> <p>Kidney Stones                Yes   No</p> <p>Sexual problems             Yes   No</p> <p>Testicle pain                 Yes   No</p> | <p><input type="checkbox"/> <b>Genitourinary - Female Only</b></p> <p>Blood in urine               Yes   No</p> <p>Kidney Stones                Yes   No</p> <p>Sexual problems             Yes   No</p> <p>Menstrual problems        Yes   No</p> | <p><input type="checkbox"/> <b>Psychiatric</b></p> <p>Insomnia                     Yes   No</p> <p>Confusion/memory loss     Yes   No</p> <p>Depression                    Yes   No</p>  |

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

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Statement: I have reviewed the questionnaire with the patient.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_