Health History Questionnaire

All questions contained in the questionnaire are strictly confidential and will become part of your medical record

Name *(Last, First, MI)*:	☐ Male ☐ Female	**Age:**	**Date of Birth:**
Primary Care Physician:	**Referring Physician:**		
Referral Source: ☐ Doctor ☐ Self ☐ Friend ☐ Family ☐ Internet ☐ Other			

History of Current Problem

Chief Complaint:			
How long have you had this problem?			
What caused the problem?			
What makes your symptoms worse?			
What makes your symptoms better?			
Do you have any numbness or weakness, where?			
What other treatments have you had?		Physical Therapy ☐	Injections ☐
Have you had any tests/imaging performed?	When and where?		
Have you seen anyone else for this condition, who?			
Is it from an accident? Yes ☐ No ☐	Injury Date:	Is it work related? Yes ☐ No ☐	Last day worked:

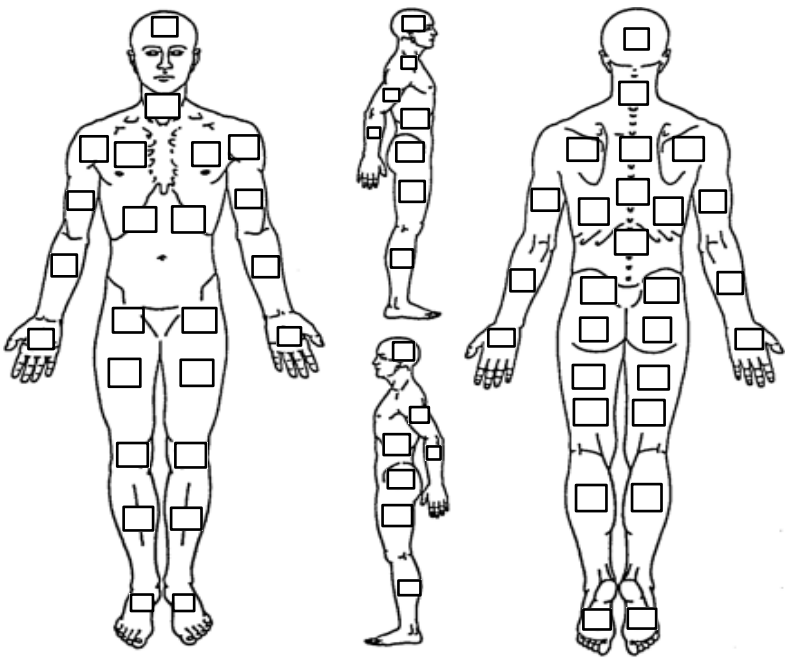
Pain Level

Rate your pain in each area on a scale of 1-10

Back:	0	1	2	3	4	5	6	7	8	9	10
R Leg:	0	1	2	3	4	5	6	7	8	9	10
L Leg:	0	1	2	3	4	5	6	7	8	9	10
Neck:	0	1	2	3	4	5	6	7	8	9	10
R Arm:	0	1	2	3	4	5	6	7	8	9	10
L Arm:	0	1	2	3	4	5	6	7	8	9	10

Pain Diagram

Please mark or shade the areas where you are having pain



Past Medical History

Please circle or write-in each applicable diagnosis

Allergic/Immunologic	**Cardiovascular**	**Ears, Eyes, Nose, Throat**	**Endocrine**
☐ Allergies/Hay Fever	☐ Hypertension ☐ Heart Attack	☐ Glasses/Contacts	☐ Diabetes→Controlled ☐ Uncontrolled ☐
☐ Autoimmune Disorder	☐ Pacemaker ☐ High Cholesterol	☐ Hard of Hearing	☐ Thyroid Problems
☐ HIV/AIDS	☐ A-fib ☐ Heart Failure	☐ Tinnitus/Vertigo	☐ Adrenal Disorder
Other:_____	☐ Stents Other:_____	Other:_____	Other:_____
Gastrointestinal	**Genitourinary**	**Hematologic/Lymph**	**Integumentary**
☐ Ulcers	☐ Cancer ☐ Kidney Disease	☐ Lymphedema	☐ Cancer
☐ Hepatitis	☐ Dialysis ☐ Prostate Problems	☐ Bleeding Disorder	☐ Chronic wounds or poor wound healing
Other:_____	☐ Sexual Dysfxn Other:_____	Other:_____	Other:_____
Musculoskeletal	**Neurologic**	**Psychiatric**	**Respiratory**
☐ Rheumatoid or Osteoarthritis	☐ Seizures ☐ Parkinson's	☐ Depression	☐ O2 use ☐ COPD or Asthma
☐ Osteoporosis	☐ Migraines ☐ Stroke	☐ Anxiety	☐ CPAP ☐ Pulmonary Fibrosis
Other:_____	☐ Dementia Other:_____	Other:_____	☐ Sleep Apnea Other:_____

I have no medical history ☐

Past Surgical History

Please list **ALL past surgeries & implanted devices**. If you've had any ***BRAIN, NECK or BACK*** surgeries, list the surgeon & year it was performed

Quality Metrics

	Yes	**No**	**Date**
Have you had a Flu vaccine?			
Have you had the Covid vaccine?			
Have you had a Pneumonia vaccine?			
Have you had a Colonoscopy?			
Have you had a Mammogram?			
Have you ever had a blood transfusion?			
Have you ever had problems with anesthesia?			

Social History

Please check those applicable to you

Marital Status	Alcohol	Tobacco
Married ☐ Widowed ☐ Divorced ☐ Other:_____ Single ☐	No, I don't drink alcohol at all ☐ Yes, I drink alcohol ☐ Frequency? _____	Tobacco use: None ☐ Current ☐ Past ☐ Type? _____ Packs per day? _____
Drugs	**Occupation**	**Handedness**
I've never used illicit drugs ☐ I used illicit drugs in the past ☐	_____ Retired ☐ Disabled ☐ Other:_____	Left-Handed ☐ Right-Handed ☐

Family Health History

Please place a check next to those applicable to you

	Cancer	Diabetes	Cardiac Disease	Stroke	Brain Tumor	Abnormal Bleeding/Clotting	Other
Father							
Mother							
Sibling							
Child							

I have no family history to report ☐

Medication Review

List ALL medications and supplements you are currently taking (including OTC vitamins and herbals)

Please list the medication name, strength in milligrams, and dosage frequency as written on the prescription bottle

I take no rx/OTC medications, herbals, or supplements ☐

If you have additional medications, there is more space at the end of the document.

Allergy Review

List **ALL** drug, food, and/or medical allergies:

Allergy	**Reaction**

Are you allergic to the following?	IV Dye or Contrast? **Y**☐ **N**☐	Latex? **Y**☐ **N**☐	Iodine? **Y**☐ **N**☐

I have no allergies to report ☐

Systems Review

Check all current symptoms and add additional as needed

Cardiovascular	Constitutional	Ears, Eyes, Nose, Throat
☐ Palpitations	☐ Fatigue	☐ Blurry/Double vision
☐ Chest Pain	☐ Fever/Chills	☐ Trouble Swallowing
☐ Leg Swelling	☐ Rapid Weight Loss or Gain	☐ Eye Pain
Other:_____	Other:_____	Other:_____

Gastrointestinal	Genitourinary	Hematologic/Lymph	Musculoskeletal
☐ Abdominal Pain	☐ Pain with Urination	☐ Easy Bruising	☐ Neck Pain
☐ Nausea or Vomiting	☐ Incontinence	☐ Prolonged Bleeding	☐ Back Pain
☐ Bowel incontinence	☐ Urgency	☐ Lymph Node Swelling	☐ Muscle Weakness
Other:_____	Other:_____	Other:_____	Other:_____

Neurologic	Psychiatric	Respiratory
☐ Trouble Walking	☐ Insomnia	☐ Cough
☐ Headaches	☐ Suicidal Thoughts	☐ Snoring
☐ Tremors	☐ Anxiety	☐ Shortness of Breath
☐ Numbness/Tingling	☐ Depression	☐ Wheezing
Other:_____	Other:_____	Other:_____

I have none of the above symptoms ☐

Do you have any other pertinent history, symptoms, or information to provide?

_____

_____

_____

_____

By signing below, you certify that the included information is accurate and inclusive of all information relevant to your care.

Patient Signature:_____ Date:_____

For Office Use Only

Height	Weight	BMI	Temp	Blood Pressure