Medical History Questionnaire

Appointment with _____ Referred by _____

Patient Name: _____ DOB: _____ Date: _____

Please complete this medical questionnaire to inform your physician. Please circle the appopriate response(s) where applicable:

1. Cheif Complaint (brief statement): (example: I fell down at work and hurt my left knee)

   _____

2. History: Right handed Left handed

   Age: _____ Date of injury: _____

   Where and when you were first seen for this problem: _____

   _____

   If you can remember, please list the doctor(´s) name(s) and approciamte dates when they saw you for this problem:

   _____

   Plase list any tests that have been performed fot this injury:

   X-Rays MRI EMG CAT Scan Ultrasound Bone Scan Other: _____

   Please list any treatments that have been performed for this injury:

   Physical Therapy Chiropractic Adjusments Work Hardening Massage Pain Clinic Other: _____

   Have you ever injured this are of your body before? Yes No

   If yes, please give approximate date: _____

3. Work History: Employer: _____ Type of Work _____

   How long have you been employed by this company? _____

   If you are not presently employed, are you: Retired Unemployed Disabled Homemaker Student

   Are you diabetic? Yes No

4. Drug Aleergies and Reactions (ex. Penicillin, Ionide, tape, latex) (ex. Of side effects: rash, swelling, difficulty breathing)

   _____

Clinical Notes: (for Doctor´s use only)

_____

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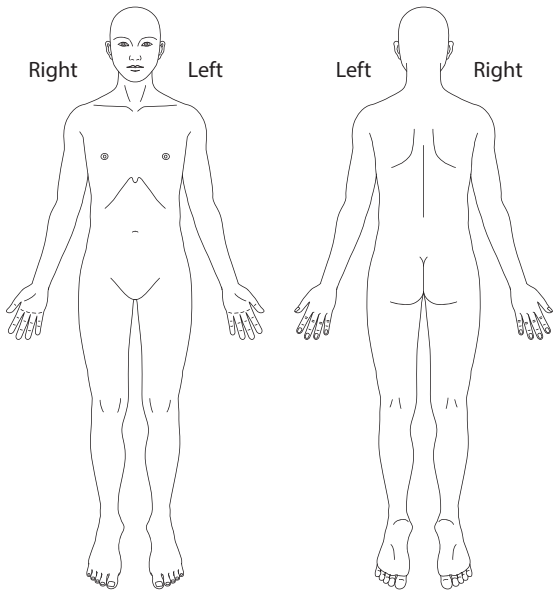
Please mark an „X“ where you are having pain



5. Medications (list names of medications or types of medications wich you are currently taking)

_____

_____

_____

6. Medical History: (circle appropriate responses)

Heart attack/coronary artery disease/heart surgery
Hypertension
High Cholesterola
Vascular/Circulation Problems
Blood clots
GI/Peptic Ulcer Disease
GERD
Gastritis
Hepatitis

Asthma
Emphysema
Pneumonia
Kidney Failure/Insufficiency
Bladders Problems
Sleep Apnea
Stroke/TIA
Epilepsy
Recent Weight Loss

Osteoporosis
Abnormal Bleeding/Clotting
Diabetes
Thyroid Disease
Cancer
Bone Infection
HIV/AIDS
Gout

7. Surgival History (list major operations along with the date the procedure was done)

_____

_____

_____

Have you ever had a blood transfusion?	Yes	No
Have you ever used recreational intravenous drug?	Yes	No
Do you have tattoos?	Yes	No

8. Social History: Marital Status: Married Window(er) Single Oivorced

Tobacco Use: Yes No How much do you smoke? _____ For how many years? _____

Do you drink alcohol beverages? Yes No Type and nubmer per week: _____

9. Family History (list illnesses that run or occur in your family, example: diabetes heart disease, hypertension, stroke, cancer, bleeding disorders, arthritis, tuberculosis, blood clots)

_____

10. Review of Systems: Are you presently having problems with any of the systems listed below

General: weight loss, fatigue, weakness, fever, chills, night sweats
Skin: rashes, sores, lumps, tattoos
Head: trauma, headache, nausea, vomiting, visual changes
Eyes: glasses, contact lenses, blurriness, double vision
Mouth, Throat, Neck: bleeding gums, sore throat
Cardiac: hypertension, murmurs, chest pain, palpitations, difficult or labored breathing, heart condition
Respiratory: shortness of breath, wheezing, cough, spitting blood, pneumonia, asthma, bronchitis, emphysema, tuberculosis
GI: bleeding, pancreatitis, hemorrhoids, black tarry stool, GI bleeding, vomiting of blood, abdominal pain, jaundice, hepatitis
Urinary: frequency, painful or difficult urination, blood in urine, incontinence, stones, infection
Vascular: leg swelling (fluid) claudication, varicose veins, blood clots
Musculoskeletal: joint stiffness, joint swelling, gout
Neurologic: numbness, tingling, tremors, weakness, paralysis, seizures, stroke
Hematologic: anemia, easy bruising/bleeding, transfusions
Endocrine: thyroid problems, diabetes
Psychiatric: anxiety, depressions, memory loss

11. Osteoporosis Questionnaire:

Are you a woman over the age of 45 and have gone through menopause, or had a hysterectomy?	Yes	No
Are you a woman over the age of 45 or a man over the age of 65 or on thyroid, cortisone, or asthma medications?	Yes	No
Have you broken a bone after the age of 40?	Yes	No
Do you smoke at this time or have you ever been a moderate to heavy smoker in the past?	Yes	No
Do you drink more than two alcoholic drinks a day on average?	Yes	No
Have you lost an inch of height?	Yes	No
Did/Do your parent(s) or sibling(s) have Osteoporosis or have had a broken/fractured bone?	Yes	No

If you answered yes to two or more of these items, please discuss the possibility of osteoporosis screening with your doctor.