

# PATIENT MEDICAL HISTORY QUESTIONNAIRE

NAME \_\_\_\_\_ DATE \_\_\_\_\_

Reason for Visit(what's wrong) \_\_\_\_\_

Is this visit work related Y or N Auto Accident Related Y or N Other Accident Y or No \_\_\_\_\_

Who referred you to this office for consultation? \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_(full name please)

**REVIEW OF SYSTEMS - PLEASE CIRCLE ANY OF THE FOLLOWING HEALTH PROBLEMS WHICH YOU HAVE OR HAVE HAD.**

- |                            |                                       |                             |
|----------------------------|---------------------------------------|-----------------------------|
| Y N Asthma                 | Y N Gout                              | Y N Measles                 |
| Y N Arthritis              | Y N Heart Attach/Heart Problems       | Y N Mitral Valve Disease    |
| Y N Balance Problems       | Y N Hepatitis                         | Y N Mumps                   |
| Y N Bladder/bowel problems | Y N Herpes                            | Y N Muscular Dystrophy      |
| Y N Blood Clots/bleeding   | Y N High Blood Pressure(Hypertension) | Y N Pancreatitis            |
| Y N Black outs/fainting    | Y N High Cholesterol                  | Y N Polio                   |
| Y N Cancer (Where_____)    | Y N H.I.V.                            | Y N Shingles                |
| Y N Digestive Problems     | Y N Kidney Disease                    | Y N Stroke (when?_____)     |
| Y N Diabetes               | Y N Kidney Stone                      | Y N Ulcers                  |
| Y N Emphysema              | Y N Lupus                             | Y N Urinary Tract Infection |
| Y N Eye problems           | Y N Lung problems                     | Y N Other _____             |
| Y N Ear problems           |                                       |                             |

**MEDICATIONS - Please list all Medications that you are currently taking**

Medication	Strength	How Often	Medication	Strength	How Often

Are you allergic to any medications? \_\_\_\_\_

**PAST SURGICAL HISTORY**

- |                          |                     |                    |
|--------------------------|---------------------|--------------------|
| Y N Appendectomy         | Y N Colostomy       | Y N Mastectomy     |
| Y N Abdominal            | Y N Colon Resection | Y N Prostate       |
| Y N Bladder              | Y N Heart           | Y N Tonsillectomy  |
| Y N Breast Biopsy        | Y N Hemorrhoids     | Y N Tubal Ligation |
| Y N Cataract             | Y N Hernia          | Y N Vasectomy      |
| Y N Gall Bladder removal | Y N Hysterectomy    | Y N Other _____    |

**ORTHOPEDIC HISTORY**

- Y N Arthroscopy  
of what: \_\_\_\_\_
- Y N Joint Replacement  
where? \_\_\_\_\_
- Y N Fractures-of what \_\_\_\_\_
- Y N Back Surgery-when? \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date