**Health History Questionnaire**

**Allergy/Immuno**

Please list all allergies:

**Medications**

Please list all medications:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Amyotrophic Lateral Depression** |  | **Asthma** |  | **Cholelithiasis** |  |
| **Depression** |  | **Hiatal Hernia** |  | **Inflammatory bowel disease** |  |
| **Osteoporosis** |  | **Renal insufficiency** |  | **Thrombophlebitis** |  |
| **Anemia** |  | **Bleeding Disorder** |  | **Chronic Bronchitis** |  |
| **Diabetes Mellitus** |  | **History of blood reaction** |  | **Jaundice** |  |
| **Pancreatitis** |  | **Rheumatic Heart Disease** |  | **Thyroid Disease** |  |
| **Angina** |  | **Blood dyscrasia** |  | **Cirrhosis** |  |
| **Diabetes Mellitus type I** |  | **History of blood transfusion** |  | **Kidney Disease** |  |
| **Pulmonary arterial hypertension** |  | **Seizures** |  | **TMJ problem** |  |
| **Anxiety** |  | **Cancer** |  | **COPD** |  |
| **Diverticulitis** |  | **Hypertension** |  | **Liver Disease** |  |
| **Pulmonary embolism** |  | **Sleep apnea** |  | **Tuberculosis** |  |
| **Arrhythmia** |  | **Cataracts** |  | **Coronary artery disease** |  |
| **Glaucoma** |  | **Hypoglycemia** |  | **Multiple sclerosis** |  |
| **Pyloric stenosis** |  | **Sleep Apnea-obstructive** |  | **Ulcerative colitis** |  |
| **Arthritis** |  | **CHF** |  | **Deep Vein Thrombosis** |  |
| **Hepatitis** |  | **Hypothyroidism** |  | **Myocardial Infraction** |  |
| **Renal Disorder** |  | **Stroke** |  |  | |

**Medical History: Please check box if applicable**

**Have you been diagnosed with cancer in the last two years?** Yes No

**Anesthesia History**

Please list history of reactions:

**Surgical History**

Please check box, if applicable:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Join replacement |  | Back Surgery |  | Vascular Surgery |  |
| Fracture surgery |  | Heart Surgery |  | Brain Surgery |  |

Please list other surgeries:

**Family History**

Please indicate with a check mark for family members who may have had any of the following conditions:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Relationship | Diabetes | Cancer | Anesthesia problems | Gastric Ulcer | Lupus | Rheumatoid Arthritis | Blood disorder | Heart disease |
| Mother |  |  |  |  |  |  |  |  |
| Father |  |  |  |  |  |  |  |  |
| Sister |  |  |  |  |  |  |  |  |
| Brother |  |  |  |  |  |  |  |  |
| MGM |  |  |  |  |  |  |  |  |
| MGF |  |  |  |  |  |  |  |  |
| Maternal aunt |  |  |  |  |  |  |  |  |
| Maternal uncle |  |  |  |  |  |  |  |  |
| PGM |  |  |  |  |  |  |  |  |
| PGF |  |  |  |  |  |  |  |  |
| Paternal aunt |  |  |  |  |  |  |  |  |
| Paternal uncle |  |  |  |  |  |  |  |  |

**Social History**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Tobacco Use : | Yes | No | Former | If yes how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |
| --- | --- | --- | --- |
| Alcohol use : | Yes | No | If yes how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Sexually Active?**

|  |  |  |
| --- | --- | --- |
| Yes | No | What form of birth control do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **Genitourinary** | |
| No Symptoms |  |
| Difficulty urinating |  |
| Dysuria (Painful urination) |  |
| Enuresis |  |
| Flank pain |  |
| Frequency |  |
| Genital sore |  |
| Hematuria |  |
| Urgency |  |
| Urine decreased |  |

**Please check the box if you have experienced any of these symptoms:**

|  |  |
| --- | --- |
| **Musculoskeletal** | |
| No Symptoms |  |
| Arthralgias (Joint pain) |  |
| Back Pain |  |
| Gait problem |  |
| Myalgias |  |
| Neck pain |  |
| Neck Stiffness |  |

|  |  |
| --- | --- |
| **Neurological** | |
| No Symptoms |  |
| Dizziness |  |
| Facial asymmetry |  |
| Headaches |  |
| Light headedness |  |
| Numbness |  |
| Seizures |  |
| Speech difficulty |  |
| Syncope (Fainting) |  |
| Tremors |  |
| Weakness |  |

|  |  |
| --- | --- |
| **Cardiovascular** | |
| No Symptoms |  |
| Chest Pain |  |
| Leg swelling |  |
| Palpitations |  |

|  |  |
| --- | --- |
| **Skin** | |
| No Symptoms |  |
| Color change |  |
| Pallor |  |
| Rash |  |
| Wound |  |

**Have you ever had any of the following tests or treatments done for this injury/problem? Please circle if applicable.**

CT scan MRI X-Ray Bone Scans

Occupational Therapy Physical Therapy EMG Spinal Injection

**How would you describe your daily activities?**

Sitting for long periods Lifting/ pushing/pulling Standing for long periods Bending, Squatting

Repetitive Movements Moderate to heavy walking Moderate to heavy physical activity/labor

**If you’re being seen for an injury, please answer the following questions:**

1. **If you have an injury, how did it occur?**

Fall Hit by an object Auto Accident Work-related

Sport/recreational Routine daily activity Physical Abuse Other

1. **Where did it occur?**

Home Work Public Place Car/motorcycle Outdoors Other

1. **Is an Attorney Involved in your injury?** Yes No
2. **Are you claiming the problem as a work related injury?** Yes No