

# MEDICAL QUESTIONNAIRE

## Identification

Name \_\_\_\_\_ Date \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

### **Gender**

Male  Female

### **Hand Dominance**

Left  Right

### **Ethnic Group**

Caucasian  Hispanic  Black  Asian  Other

Date of motor vehicle accident or injury: \_\_\_\_\_

Approximate date your illness started: \_\_\_\_\_

What is the main problem you want addressed?

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## Allergies

List any medication allergies, or sensitivities to medications:

- |                                  |                                    |                                       |  |
|----------------------------------|------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> NONE    | <input type="checkbox"/> Lidocaine | <input type="checkbox"/> Procaine     | <input type="checkbox"/> Hydrocodone (Vicodin)           |
| <input type="checkbox"/> Tylenol | <input type="checkbox"/> Morphine  | <input type="checkbox"/> Penicillin   | <input type="checkbox"/> Oxycodone (Percocet, oxycontin) |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine   | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> OTHER _____                     |

Please describe in detail your allergic reaction (shortness of breath, hives, itching, fast heart rate, etc.) or type of sensitivity (upset stomach, diarrhea, foggy thinking).

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Please list all of your medications, including dose amount and how often you take the medication.

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## Past Medical History

Please list your medical history, diseases, or problems mark (x) for current problems, check (✓) for past problems and indicate age when you had any of the following symptoms or diseases.

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol  | <input type="checkbox"/> Heart Disease          |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Thyroid Disease        |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> HIV/AIDS            | <input type="checkbox"/> Bleeding Diseases | <input type="checkbox"/> Anxiety or Nervousness |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Drug Addiction      | <input type="checkbox"/> Cancer            | <input type="checkbox"/> Arthritis              |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Chronic Pain        | <input type="checkbox"/> Fibromyalgia      | <input type="checkbox"/> Other _____            |

## Past Surgical History

Please list all of your surgeries:

- |                                      |   |   |                                       |
|--------------------------------------|---|---|---------------------------------------|
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Cesarean Section | <input type="checkbox"/> Neck (level _____) | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Tonsils     | <input type="checkbox"/> Appendix         | <input type="checkbox"/> Back (level _____) | <input type="checkbox"/> Other _____  |

**Review of Systems**

Have you had any of the following problems?

- Chest Pain
- Shortness of Breath
- Fever
- Night Sweats
- Alcoholism
- Other \_\_\_\_\_
- Weight change
- Swollen nodes
- HIV/AIDS
- Drug Addiction
- Problems with ears, nose or throat
- Blood in stool/urine
- Abdominal pain
- Bleeding Diseases
- High Blood Pressure
- Heart Disease
- Thyroid Disease
- Anxiety or Nervousness
- Arthritis
- Problems with digestion

**Family History**

Does anyone in your family have any of the following?

- Hypertension
- Drug abuse
- Diabetes
- Alcoholism
- Heart disease
- Chronic pain
- Neck or back pain
- Bleeding disorders
- Thyroid disease
- Prostate Cancer
- Breast, uterine, or ovarian Cancer
- Other \_\_\_\_\_

**Social History**

- Single
- Married
- Partnered
- Divorced
- Separated
- Widowed

Indicate highest level of education attained:

- High School with diploma or GED
- College Degree
- Vocational Training
- Advanced Degree
- some College

What type of work do you do? \_\_\_\_\_

Are you?  Retired  on Disability  on Worker's Comp

Tobacco use:  Yes  No

If yes, how many years? \_\_\_\_\_

When did you quit? \_\_\_\_\_

Have you ever smoked?  Yes  No

Number of packs per day? \_\_\_\_\_

Do you want to stop?  Yes  No

Alcohol use: How much? \_\_\_\_\_

How often? \_\_\_\_\_

Does alcohol cause any problems?  Yes, please describe \_\_\_\_\_  No

Nonprescription drug use including over the counter and recreational drugs (use back if needed): \_\_\_\_\_

Exercise routine (weight lifting, aerobic classes, walking): \_\_\_\_\_

**Functional History**

Check all tasks that are most difficult for you:

- Walking
- Sitting
- Heavy chores
- Cooking
- Light chores
- Reading
- House cleaning
- Vacuum
- Exercise
- Laundry
- Sleeping
- Working
- Driving
- Watching TV
- Physical therapy

How do your symptoms and health affect your activities now? Please describe your area of concern. \_\_\_\_\_

Sexual function or interest: \_\_\_\_\_ Social or recreational participation: \_\_\_\_\_