

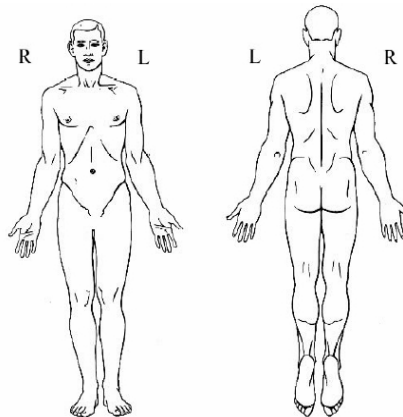
HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Age: _____
Referred By: _____		
Primary Care Physician: _____	Office use only:	
Preferred Pharmacy & Location: _____		

Reason for visit: _____

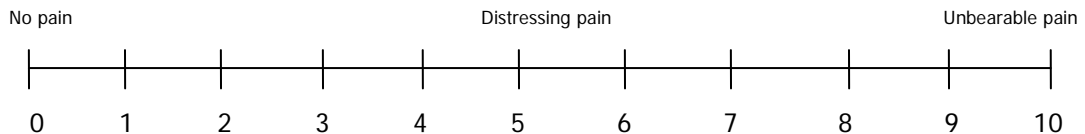
Indicate on the drawing below where your problem is and how it feels

- Aching: $\Delta\Delta\Delta$
- Burning: XXX
- Numbness: $===$
- Pins & Needles: 000
- Stabbing: $///$



How long have you had this problem? _____ Weeks _____ Months _____ Years

Circle a number from 0 to 10 that best describes your pain level:



What increases your pain? _____

What relieves your pain? _____

Accident Date: ____/____/____

Is your injury work or auto related?

Yes

No

Do you have an attorney for this issue?

Yes

No

List previous treatments or surgeries for your current problem and indicate results with an X:

Treatment or Surgery	Improved	Worsened	Unchanged

HEALTH HISTORY QUESTIONNAIRE

PATIENT PAST MEDICAL HISTORY			
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Neck/Back Disorder	<input type="checkbox"/> TB/Other
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Other: (list below)
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Phlebitis	<input type="checkbox"/>
<input type="checkbox"/> Bursitis	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Pneumonia	<input type="checkbox"/>
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Kidney Infections	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/>
<input type="checkbox"/> COPD	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Stroke/TIA	<input type="checkbox"/>

Explanation of above or similar conditions: _____

Family member with similar health problems: _____

I have NONE of the above listed conditions (check if applicable)

REVIEW OF SYSTEMS			
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cold/heat intolerance	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Joint swelling
<input type="checkbox"/> Appetite increase or decrease	<input type="checkbox"/> Depression/sleep disturbance	<input type="checkbox"/> Fevers, chills, night sweats	<input type="checkbox"/> Loss of smell
<input type="checkbox"/> Bone, muscle or joint problems	<input type="checkbox"/> Diarrhea/constipation	<input type="checkbox"/> Hard of hearing	<input type="checkbox"/> Nausea/vomiting
<input type="checkbox"/> Breast Disease	<input type="checkbox"/> Difficult/frequent urination	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Nearsighted/farsighted
<input type="checkbox"/> Breathing difficulties, cough	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Hormonal Disorder	<input type="checkbox"/> Psychiatric Disorder
<input type="checkbox"/> Burn upon urination	<input type="checkbox"/> Dizziness/headaches/seizures	<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Excessive bleeding/clot disorder	<input type="checkbox"/> Joint pain/stiffness	<input type="checkbox"/> Thyroid Disease

Explanation of above or similar conditions: _____

I have NONE of the above listed conditions (check if applicable)

Please list previous admissions into a hospital for illness or trauma.

When:	Where:	Why:

Please list previous major surgeries. Please include cosmetic surgeries.

When:	Where:	Why:	Surgeon:

