

**MEDICAL HISTORY QUESTIONAIRE**

|  |
| --- |
| Last Name First MI |
| Date of Birth Age |
| Referral Source: Physician Friend Insurance Company Advertisement Other  Name of source: |
| Referring Physician: Family Physician:   **Check here if you do NOT want your primary to receive notes** |
| **Are you receiving home health services? Yes No If yes, name of agency and type of service received. This includes, but is not limited to physical therapy, home health aide, nurse, wound care, etc.**  |
| What is the reason for your visit? |
| How and when did your symptoms begin? |
| How often do you experience these symptoms? Constantly (76-100% of the time) Frequently (51-75% of the time) Occasionally (26-50% of the time) Intermittently (0-25% of the time) |
| Please describe the nature of your symptoms: Sharp Dull Ache Numbness Shooting Stiffness  Burning Tingling Weakness Other |
| Please circle the intensity of your symptoms: None Unbearable Maximum 0 1 2 3 4 5 6 7 8 9 10 Minimum 0 1 2 3 4 5 6 7 8 9 10  |

Please mark (with an X) the areas on the diagram where you experience your symptoms.

****

|  |
| --- |
| **Please discuss what makes your symptoms better or worse.** |
| **Where did this injury occur? (i.e. work, car, home, etc.)** |
| **Have you had any of the following Medical Care *for this injury/episode*? If yes, when?**  CT Scan Emergency Room Care EMG MRI X-Ray Injection Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Do you now have or have you ever had the following?** Asthma Bronchitis Cancer: Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you smoke? Emphysema Chemotherapy  Bronchitis Chest Pain Radiation Shortness of Breath Chronic Pain Allergies Coronary Heart Disease Fibromyalgia Diabetes Dialysis Shunt Side: L / R Arthritis/Swollen Joints Infectious Diseases  High Blood Pressure Osteoporosis Osteopenia Latex Sensitivity/Allergy Heart Attack Heart Surgery  Severe or Frequent Headaches Blood Clot Emboli Cellulitis Bladder/Bowel Incontinence Stroke  TIA Kidney Dysfunction Atrial Fibrillation Liver Dysfunction Unexplained weight loss in the past 30 days Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Surgeries (Include date of procedure):** Pacemaker Defibrillator Deep Nerve Stimulator Deep Brain Stimulator Spinal Fusion Joint Replacement: Type \_\_\_\_\_\_\_\_\_ Mastectomy L / R Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Please list Medications (including vitamins).** |
| **Do you have allergies to medications? If yes, which ones?** |