Medical History Self Questionnaire

General Demographics:

Name_____ **Date of Birth**_____

Marital Status and living status (circle all that apply)

Married Single Live Alone Prefer not to answer

Social History:

Occupation: _____ **Employer:** _____

Highest Level of education: _____

Tobacco Use: Y or N or Past user Type _____ Packs per day _____ How long _____

Alcohol Use: Y or N If yes, estimated drinks per week _____

Caffeine Intake: Y or N If yes, cups per day _____

What are your goals for Therapy?

_____

_____

What aggravates your pain?

___ Sitting ___ Rise from sit ___ Standing ___ Lying Down ___ Straining

___ Squatting ___ Stress ___ Bending ___ Lifting ___Cough/Sneeze

___ Driving ___ Walking ___ Running ___ Stairs ___ Urination

___ Intercourse ___ Overhead Activity ___ Looking up/down ___ Turning Head

___ Bowel Movement ____Other _____

What eases your pain?

___ Rest ___ Medication ___ Changing Positions

___ Ice ___ Sitting ___ Activity _____

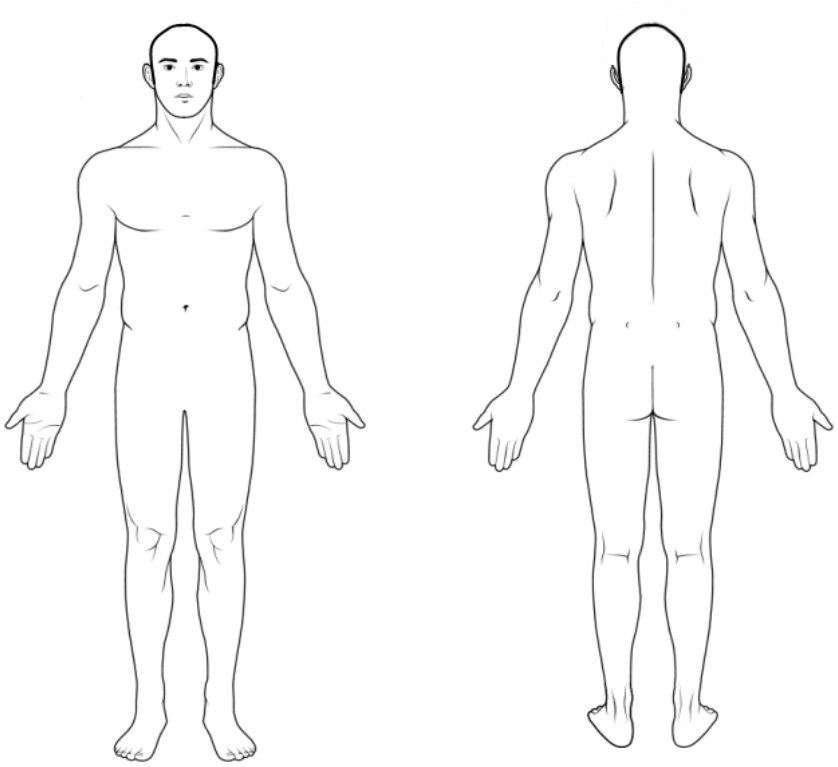
___ Heat ___ Standing ___ Stress reduction/relaxation _____

Other _____

Pain Scale-Please rank your pain for the past TWO WEEKS on the 0-10 scale, zero being NO pain!

	0	1	2	3	4	5	6	7	8	9	10
CURRENT											
WORST											
BEST											

Please mark on the Diagram any pain that you have CURRENTLY!



Medication:

Please list all medication that you are currently taking including over the counter, supplement and prescribed medications and the date you last took them.

1._____ 5 ._____

2._____ 6. _____

3._____ 7. _____

4._____ 8. _____

Surgical History:

Please list in order by year. Ex: Tonsillectomy – May 6, 1964

Name of Procedure Year

1._____

2._____

3._____

4._____

5._____

6._____

Medical History:

Do you or any of your immediate family members have any of the following?

	You	When	Family	Who
AIDS/HIV	Y or N	_____	Y or N	_____
Alcoholism	Y or N	_____	Y or N	_____
Anemia	Y or N	_____	Y or N	_____
Anesthesia Probs	Y or N	_____	Y or N	_____
Arthritis	Y or N	_____	Y or N	_____
Asthma	Y or N	_____	Y or N	_____
Behavior Disorder	Y or N	_____	Y or N	_____
Bleeding Tend.	Y or N	_____	Y or N	_____
Blood Clot (lung/leg)	Y or N	_____	Y or N	_____
Blood Transfusion	Y or N	_____	Y or N	_____
Bone Disease	Y or N	_____	Y or N	_____
Cancer	Y or N	_____	Y or N	_____
Cholesterol Probs.	Y or N	_____	Y or N	_____
Circulation Probs.	Y or N	_____	Y or N	_____
Diabetes	Y or N	_____	Y or N	_____
Depression/Anxiety	Y or N	_____	Y or N	_____
Fever	Y or N	_____	Y or N	_____
Fibromyalgia	Y or N	_____	Y or N	_____
Heart Attack (MI)	Y or N	_____	Y or N	_____
Heart Disease	Y or N	_____	Y or N	_____
Hepatitis	Y or N	_____	Y or N	_____
High Blood Pressure	Y or N	_____	Y or N	_____
Kidney Disease	Y or N	_____	Y or N	_____
Liver Disease	Y or N	_____	Y or N	_____
Lung Disease	Y or N	_____	Y or N	_____
Mood Disorder	Y or N	_____	Y or N	_____
Muscular Disease	Y or N	_____	Y or N	_____
Prostate Disease	Y or N	_____	Y or N	_____
Seizures	Y or N	_____	Y or N	_____
Sickle Cell Disease	Y or N	_____	Y or N	_____

Sleep Apnea	Y or N _____	Y or N _____
Stomach Ulcers	Y or N _____	Y or N _____
Stroke	Y or N _____	Y or N _____
Thyroid Disease	Y or N _____	Y or N _____
Tuberculosis	Y or N _____	Y or N _____
Varicose Veins	Y or N _____	Y or N _____

Other_____

Please list any allergies, type of reaction, and treatment needed (ie. epi pen):

_____

_____

_____

Review of Systems:

Have you experienced any of the following within the last 30 days? Circle all that apply.

Constitutional: Fever Chills Night Sweats Recent Weight Gain Recent Weight Loss Exercise Intolerance

Eyes: Dry Eyes Irritation Wear Glasses Wear Contacts

Ears: Ringing in Ears Difficulty Hearing/Deafness Ear Pain

Nose: Frequent Nosebleeds Nose/Sinus Problems

Mouth/Throat: Sore Throat Bleeding Gums Snoring Dry Mouth Oral Abnormalities Mouth Ulcer Teeth Abnormalities/Dentures Mouth Breathing Hoarseness Dental Infections

Cardiovascular: Chest Pain w/ Exertion Arm Pain w/ Exertion Shortness of Breath When Walking Palpitations Shortness of Breath When Lying Down Swelling in Legs Known Heart Murmur Irregular Heart Beat Fainting

Respiratory: Cough Wheezing Shortness of Breath Coughing Up Blood Sleep Apnea

Gastrointestinal: Abdominal Pain Vomiting Change in Appetite Black or Tarry Stools Frequent Diarrhea Vomiting Blood Nausea Heartburn

Genitourinary: Urinary Loss of Control Difficulty Urinating Increased Urinary Frequency Hematuria

Incomplete Emptying Burning with Urination Difficulty Starting Stream

Musculoskeletal: Muscle Aches/Stiff Muscle Weakness Arthralgia/Joint Pain Back Pain Swelling in Extremities

Integumentary: Abnormal Mole Jaundice Rash Itching Dry Skin Growths/Lesions Tattoos Masses

Neurologic: Loss of Consciousness Weakness Numbness Tingling Seizures Dizziness Migraines

Restless Legs Frequent/Severe Headaches Problems w/ Speech Visual Change Balance Problems

Psychiatric: Depression Sleep Disturbances Restless Sleep Feeling Unsafe in Relationship Alcohol Abuse,

Eating Disorder Anxiety Hallucinations

Endocrine: Fatigue Increased Thirst Hair Loss Increased Hair Growth Cold Intolerance Heat Intolerance

Hematology/Lymphatic: Bleeding Tendency Swollen Glands Night Sweats

Patient Signature _____ Date

_____

Therapist Signature _____ Date

_____