HEALTH HISTORY QUESTIONAIRRE

All information in this questionnaire to remain strictly confidential and will be part of your medical record.

Name ☐ M ☐ F			DOB:
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Work Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled		Height Weight	
Primary Care Physician:	Address:		Phone:
Pulmonologist:	Address:		Phone:
Cardiologist:	Address:		Phone:
Other Physician:	Address:		Phone:
Have you been treated for this problem in the past?	☐ Yes ☐ No If so, by whom and when:		

CURRENT SYMPTOMS AND TREATMENTS

Which Of The Following Are You Currently Experiencing? (Please Select All That Apply)

Arm/Hand Weakness	☐	Left ☐ Right☐	Neck Pain	☐	
Leg/Foot Weakness	☐	Left ☐ Right☐	Low Back Pain	☐	
Arm/Hand Numbness/Tingling	☐	Left ☐ Right☐	Difficulty Walking/Balance Issues	☐	
Leg/Foot Numbness/Tingling	☐	Left ☐ Right☐	Headache	☐	
Arm/Hand Pain	☐	Left ☐ Right☐	Bowel or Bladder Problems	☐	
Leg/Foot Pain	☐	Left ☐ Right☐	Other:		

Which Of These Have You Tried For This Problem: (please select all that apply)

Physical Therapy	☐	Office Name:	Dates:
Chiropractic Manipulation	☐	Office Name:	Dates:
Massage Therapy	☐	Office Name:	Dates:
Pain Management	☐	Office Name:	Dates:
Epidural Steroid Injection	☐	Office Name:	Dates:
TENS Unit	☐	Office Name:	Dates:

Which Medications Have You Tried For This Problem: (please select all that apply)

NSAIDs (ibuprofen, etc.)	☐	Date Started:	Date Finished:	Did it Help?	Yes ☐	No ☐
Narcotics	☐	Date Started:	Date Finished:	Did it Help?	Yes ☐	No ☐
Muscle Relaxers	☐	Date Started:	Date Finished:	Did it Help?	Yes ☐	No ☐

List any other medications you have tried for this problem:

PAST MEDICAL HISTORY

☐ High Blood Pressure	☐ Seizures	☐ Fibromyalgia	☐ Hepatitis
☐ Heart Failure	☐ Stroke	☐ RSD	☐ HIV/AIDS
☐ Angina (Chest Pain)	☐ Brain Tumor	☐ Urinary Tract Infection	☐ Tuberculosis
☐ Coronary Artery Disease	☐ Ulnar Nerve Entrapment	☐ Rheumatoid Arthritis	☐ Kidney Disease
☐ Irregular Heart Beat	☐ Memory Problems	☐ Gout	☐ Thyroid Problems
☐ Diabetes	☐ Alzheimer's	☐ Reflux/Heart Burn	☐ Compression Fracture
☐ Valve Replacement	☐ Dementia	☐ Blood Clots	☐ Anxiety
☐ High Cholesterol	☐ Parkinson's Disease	☐ Bleeding Disorder	☐ Depression

PAST MEDICAL HISTORY CONTINUED			
☐ MS	☐ Neuropathy	☐ Emphysema/COPD	☐ Other:
☐ Brain Aneurysm	☐ Hydrocephalus	☐ Osteoporosis	
☐ Migraines	☐ Carpal Tunnel Syndrome	☐ Asthma	
☐ MRSA	☐ Nerve Tumor	☐ Sleep Apnea	
☐ Heart Attack /Date(s):		☐ Cancer/Type:	
Are you allergic to (please select all that apply): ☐ Contrast Dye ☐ Seafood ☐ Latex ☐ Penicillin ☐ Sulfa			
List any other allergies:			

FAMILY MEDICAL HISTORY

Do any family members have any of the following medical problems?

Disorder	Family Member	Disorder	Family Member
☐ High Blood Pressure		☐ Stroke	
☐ Diabetes		☐ Bleeding Disorder	
☐ Brain Tumor		☐ Heart Disease	
☐ Cancer		☐ Seizures	
☐ Brain Aneurysm		☐ Dementia	
☐ Arthritis		☐ Spine Problems	

PERSONAL HEALTH HISTORY

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

MEDICATION	STRENGTH/DOSAGE	MEDICATION	STRENGTH/DOSAGE
What Pharmacy do you Use?		Location/Phone Number:	

List your past surgical history:

SURGERY	DATE	DOCTOR/LOCATION

Social Habits:

Do you use tobacco ☐ Yes ☐ No	Cigarettes packs/day	Chew #/day
Interested in quitting? ☐ Yes ☐ No	For how many years have you used tobacco?	or Year Quit
Do you drink alcohol? ☐ Yes ☐ No	How many drinks per week?	
Are you ☐ right handed or ☐ left handed?		

REVIEW OF SYSTEMS

Please select all that you are currently experiencing:

☐ Hearing Problems	☐ Constipation	☐ Weight Loss
☐ Neck Pain	☐ Diarrhea	☐ Weight Gain
☐ Neck Stiffness	☐ Nausea	☐ Rash
☐ Cough	☐ Vomiting	☐ Vision Changes
☐ Shortness of Breath	☐ Muscle Pain	☐ Weakness
☐ Chest Pain	☐ Headaches	☐ Abnormal Bleeding
☐ Irregular Heart Beat	☐ Numbness	☐ Other:
☐ Stomach Pains	☐ Fever	☐ Other: