Name:
DOB:
Chart:
Age:
Date:

Patient History Questionnaire

Name: _____ **Age:** _____ **Date:** _____

Have you ever been diagnosed with any of the following conditions:

- ☐ **No medical conditions**
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood clot (leg)
- ☐ Blood clot (lungs)
- ☐ Cancer (breast)
- ☐ Cancer (colon)
- ☐ Cancer (lung)
- ☐ Cancer (prostate)
- ☐ Cancer (other)
- ☐ Colitis
- ☐ COPD
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Gout
- ☐ Heart attack
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Hepatitis
- ☐ HIV
- ☐ Kidney disease
- ☐ Lupus
- ☐ Migraines
- ☐ Polio
- ☐ Seizures
- ☐ Stroke
- ☐ Stomach Ulcers
- ☐ Sickle Cell Disease
- ☐ Thyroid problem
- ☐ Tuberculosis

Please list any other medical conditions:

Have you had any of the following surgeries (check all that apply):

- ☐ **None**
- ☐ Appendix
- ☐ Gall bladder
- ☐ Open heart surgery
- ☐ Hysterectomy
- ☐ Tonsils

Total joint replacement (specify): _____

Back surgery (specify): _____

Surgery for a broken bone (specify): _____

Other: _____

Are you presently being treated for chronic pain? ☐ Yes ☐ No Physician _____

Please list all medications you currently use with dosage and frequency (include any vitamins, over the counter medication, herbal medication):

Medication	**Dosage**	**Frequency**
☐ **None**		

Preferred Pharmacy: _____

Name:
DOB:
Chart:
Age:
Date:

Patient History Questionnaire

Do you have any of the following allergies (check all that apply):

- ☐ **No allergies**
- ☐ Adhesive tape
- ☐ Arthritis medicine
- ☐ Aspirin
- ☐ Cephalosporin
- ☐ Codeine
- ☐ Dyes
- ☐ Iodine
- ☐ Latex
- ☐ Metal
- ☐ Morphine
- ☐ Mycins
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetanus

Other (please list): _____

Please explain allergic reaction: _____

Has anyone in your family had (check all that apply):

- ☐ Heart disease
- ☐ High blood pressure
- ☐ Stroke
- ☐ Diabetes
- ☐ Blood clots
- ☐ Bleeding problems
- ☐ Cancer (details): _____
- ☐ Difficulty with anesthesia
- ☐ **None**

Do you currently use tobacco products? ☐ Yes ☐ No

☐ Cigarettes ☐ Pipe ☐ Smokeless tobacco

Amount per day: _____

How long have you used tobacco products (years): _____

Quit when: _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much per week _____

What is your current occupation? _____

Have you <u>recently</u> had any of the following problems (check all that apply):

- ☐ Fevers
- ☐ Fatigue
- ☐ Weight change
- ☐ Blurry vision
- ☐ Nasal congestion
- ☐ Sore throat
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Nausea
- ☐ Vomiting
- ☐ Pain or burning when urinating
- ☐ Rash
- ☐ Numbness or tingling
- ☐ Joint pain
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Anxiety
- ☐ Depression
- ☐ Easy bleeding
- ☐ Seasonal allergies

Patient or Guardian Signature: _____

PRINT Patient or Guardian Name: _____

Physician Signature: _____ Date: _____