

MEDICAL HISTORY QUESTIONNAIRE

For office use only:

Acct#: _____
Ref. Dr. _____

B/P: _____
PULSE: _____
Ht: _____
Wt: _____

Legal Name: _____ Date: _____

Birth Date: _____ Age: _____ Sex: M F

Occupation (if retired former job(s)): _____

Hand Dominance: Right/Left/Both _____

Height _____ ft Weight _____ lbs Lifetime Maximum Weight _____

Referred by (check one): Self ___ Family ___ Friend Doctor ___ Other Health Professional ___

Name of general medical care physician(s): _____

PRESENT HISTORY:

Please briefly describe your problem(s): _____

Date of accident or onset of symptoms: _____

Do you believe your problem(s) to be work related or due to an accident or injury? If yes, please describe: _____

What makes your symptoms better? _____



What makes your symptoms worse? _____

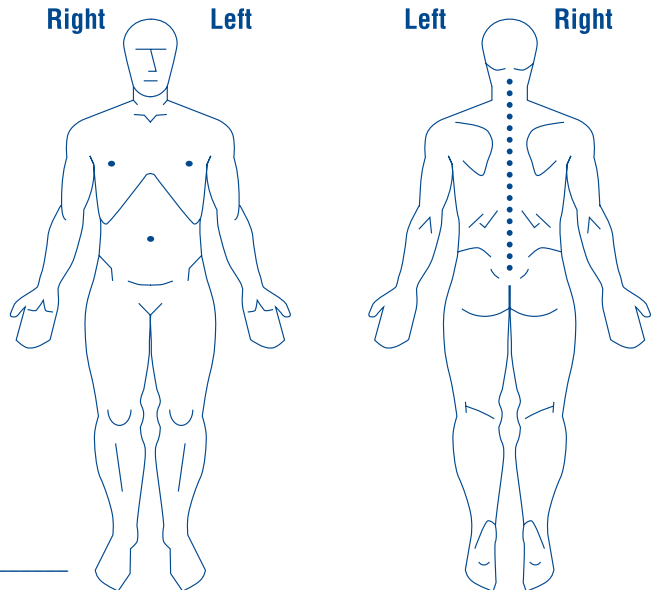
(office use only) _____

PAIN/ SYMPTOM DIAGRAM

(If applicable, please mark the parts of your body where you feel the problem. Use the appropriate symbols indicated below).

Symbols

- Ache 
- Tremors 
- Swelling 
- Pins/Needles 
- Stabbing 
- Numbness 
- Weakness 
- Popping/ Cracking/ Grinding 



Original Date: _____ **Update:** _____

PREVIOUS MEDICAL CARE or DIAGNOSTIC TREATMENT for PRESENT PROBLEM:

Please circle. Then list who, where, when, and noted results.

Self Treatment _____	Blood Work _____
Primary Care Dr _____	X-ray _____
Other Specialty Dr. _____	MRI _____
Chiropractor _____	CT Scan _____
Rehab _____	Myelogram _____
Medications _____	Bone Scan _____
Epidural Flood _____	EMG _____
Facet Joint Injection _____	Ultrasound _____
Other treatment _____	Biopsy _____
Other Testing _____	Bone Densisty Test _____

PAST MEDICAL HISTORY

Please List all Previous Operations, Illnesses or Hospitalizations:

	What	Year	Surgeon/ Hospital
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____
6	_____	_____	_____
7	_____	_____	_____
8	_____	_____	_____

*** Please attach list of hospitalizations/surgeries if not enough lines to list.**

Have you ever been treated for malignant hyperthermia under anesthesia? Yes No

Have you had any of the following conditions diagnosed or treated? Please circle if you have.

HEART: high blood pressure, heart condition, angina, angioplasty, high cholesterol, irregular heart rate, rheumatic fever, heart attack

BLOOD: anemia, blood clots, AIDS/HIV, Sickle Cell

CANCER: leukemia, lymphoma, sarcoma, skin, brain tumor, other

SKIN: eczema, psoriasis, dermatitis, melanoma

HORMONES & ENDOCRINE: diabetes, hypoglycemia, thyroid problems, adrenal or pituitary abnormalities

PSYCHIATRY: depression, nervous breakdown, drug or alcohol dependency, anxiety

DIGESTIVE: stomach ulcers, jaundice, irritable bowel disease, colitis, hepatitis

HEAD & NECK: eye surgery, cataracts, glaucoma, hearing loss, facial tic, sinusitis

NEUROLOGICAL: seizures or epilepsy, blackouts, migraine, stroke, TIA, Parkinson's, Alzheimer's or other dementia, neuropathy, carpal tunnel, multiple sclerosis

TRAUMA: neck or back injury, whiplash? When: _____, head injury, concussion? When: _____

LUNGS: asthma, pneumonia, sleep apnea, COPD, emphysema, TB (tuberculosis)

ARTHRITIS: rheumatoid, osteoarthritis, fibromyalgia, lupus, sarcoid, connective tissue disease

GENITOURINARY: kidney disease, dialysis, bladder problems, prostate disease, female organ problems

REPRODUCTIVE: miscarriages, pregnancies, delivery problems

OSTEOPOROSIS

Other medical problems not listed: _____

No conditions diagnosed or treated: _____

CURRENT MEDICATIONS:

List any medications you are taking at this time. Include aspirin, vitamins, laxatives, calcium supplements, etc.

Current Pharmacy: _____

Name of Drug	Dose (mg, IU, etc.)	Times Taken Per Day	Taken For
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

* Please attach list of all current medications if not enough lines to list.

ALLERGIES:

Please list any medication allergies, sensitivities, or intolerances: _____

Please list seasonal or environmental allergies: _____

Please list any anesthesia problems: _____

SOCIAL HISTORY:

Marital Status: (circle) Never Married / Married / Widowed / Separated / Divorced

Do you smoke or chew tobacco: Yes / No / Quit How much? _____ How Long ? _____

Do you drink alcohol? Yes / No / Quit Quit when? _____

I usually drink (circle) beer wine mixed drinks and I usually have drinks in a day / week / month (circle) _____

FAMILY MEDICAL HISTORY: please circle appropriate answers

Mother: Alive – Age: _____ If deceased cause and age of death _____

Father: Alive – Age: _____ If deceased cause and age of death _____

No. of siblings: _____ Health of siblings _____

No. of children: _____ Health of children _____

Do any of your blood relatives have the following? Please circle if they do.

AIDS	Epilepsy	Migraine Headaches
Alcoholism	Heart Disease	Multiple Sclerosis
Alzheimer's or other dementia	High Blood Pressure	Muscle disease
Asthma	High Cholesterol	Neuropathy
Bleeding Tendency	Leukemia	Parkinson's Disease
Cancer	Lupus	Rheumatoid Arthritis
Colitis	Malignant Hyperthermia under anesthesia	Stroke
Diabetes		Tremor

REVIEW OF SYSTEMS: Please mark YES or NO. If answering YES, then CIRCLE all CURRENT conditions including today's problem:

- | | |
|---|---|
| Yes No
<input type="checkbox"/> <input type="checkbox"/> | GENERAL: weight loss or gain, change in appetite, chills, fever, sweats, swollen glands, excessive sleepiness, insomnia |
| <input type="checkbox"/> <input type="checkbox"/> | ENDOCRINE: blood sugar too high or too low, cold or heat intolerance, menopausal symptoms, pregnancy |
| <input type="checkbox"/> <input type="checkbox"/> | BLOOD: bleeding tendency, anemia, blood clots, DVT, Pulmonary Emboli (PE) |
| <input type="checkbox"/> <input type="checkbox"/> | EYES: double vision, pain, loss of vision, flashing lights WEAR: glasses, contacts |
| <input type="checkbox"/> <input type="checkbox"/> | EARS/NOSE/MOUTH/THROAT: hearing problem, sinus nosebleeds, sinus discharge, hay fever, throat or mouth soreness, hoarseness, loud snoring |
| <input type="checkbox"/> <input type="checkbox"/> | RESPIRATORY: shortness of breath, cough, wheezing, coughing up blood |
| <input type="checkbox"/> <input type="checkbox"/> | CARDIAC: chest pain, heart palpitations, poor exercise tolerance |
| <input type="checkbox"/> <input type="checkbox"/> | DIGESTIVE: constipation, diarrhea, black stool, heartburn (reflux), abdominal pain |
| <input type="checkbox"/> <input type="checkbox"/> | GENITOURINARY: blood in urine, burning on urination, kidney or bladder infection, bladder control problem, urination interfering with sleep, sexual problems, vaginal or penile discharge, menstrual irregularities |
| <input type="checkbox"/> <input type="checkbox"/> | MUSCULOSKELETAL: pain in joints, pain in muscles, weakness, joint swelling, backache, broken bones, metal implants |
| <input type="checkbox"/> <input type="checkbox"/> | NEUROLOGICAL: dizziness, tremor, tingling, numbness, paralysis, imbalance, memory loss, headaches, facial pain |
| <input type="checkbox"/> <input type="checkbox"/> | SKIN/BREAST: rashes, open sores, bruising, swelling, inflammation, breast lumps |
| <input type="checkbox"/> <input type="checkbox"/> | PSYCHIATRIC: nervousness, mood changes, sleep disturbances, agitation, hallucinations |
| <input type="checkbox"/> <input type="checkbox"/> | OSTEOPOROSIS |
| <input type="checkbox"/> <input type="checkbox"/> | All other systems negative |

Other current conditions not listed: _____

Patient or Designee _____ Date _____

Physician or PA _____ Date _____

CNOS Clinical Staff Signature _____