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PATIENT QUESTIONNAIRE

Patient Name: **Date:**

Age: **Birth Date:** **Are you ☐ Right or ☐ Left handed?**

Occupation: **Employer:**

Primary Physician: **Who referred you to our office?**

CHIEF COMPLAINT

Why are you seeing the Doctor Today?

Current problem is a result of a(n): ☐ Car Accident ☐ Work Accident ☐ Injury ☐ Other

HISTORY

Date symptoms started or date injury occurred:

Area of body involved (☐ Right - ☐ Left):

Describe the problem:

When does the problem occur?

How often does this occur?

How long does it last?

What makes the problem better?

What makes the problem worse?

Circle your level of pain: None - Mild - Moderate - Severe - Unbearable

What do you think is the cause of your problem?

ASSOCIATED SYMPTOMS (Check all that apply)

- ☐ pain
- ☐ swelling
- ☐ limited motion
- ☐ locking or catching
- ☐ giving out
- ☐ weakness
- ☐ tingling
- ☐ numbness
- ☐ fever/chills
- ☐ redness
- ☐ pain worse at night
- ☐ problem is constant
- ☐ problem is intermittent
- ☐ problem is activity related

TREATMENTS AND TESTING

What medications have you tried for this problem?

Physical Therapy? (☐ Yes - ☐ No) When? Where?

X-rays? (☐ Yes - ☐ No) When? Where?

MRI ? (☐ Yes - ☐ No) When? Where?

List any other treatments or testing done for this problem:

PAST & CURRENT MEDICAL PROBLEMS

Surgeries - Hospitalizations	**Year**	**Complications**

Have you ever had general anesthesia? ☐ No ☐ Yes
Any problems with anesthesia? ☐ No ☐ Yes Describe:

LIST YOUR **MEDICATIONS** AND DOSES

☐ Check here if instead of hand writing your medications you are submitting a legible copy of your med list

ALLERGIES – below list all your **MEDICATION ALLERGIES** & describe your reaction

☐ No known medication allergies ☐ Iodine Allergy ☐ Latex Allergy ☐ Adhesive Tape Allergy

SOCIAL HISTORY

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Live with Partner
Children? ☐ No ☐ Yes #_____ How many people live in the home?_____
Do you drive? ☐ Yes ☐ No If no, who drives for you ?_____
Do you have to climb stairs to get to your bedroom? ☐ Yes ☐ No Your bathroom? ☐ Yes ☐ No
Do you Exercise? ☐ Never ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely
What type of exercise?_____
Hobbies:_____
Smoke currently? ☐ No ☐ Yes _____ Packs per day for _____ years.
Quit smoking? ☐ This year ☐ > 1 year ago ☐ > 5 years ago ☐ > 10 years ago
How much alcohol do you drink? ☐ None ☐ Rarely or # of Drinks____ ☐ Daily ☐ 1-2 x/week ☐ 1-2 x/month

FAMILY HISTORY

Do any medical problems run in your family? ☐ No ☐ Yes Describe:

Any Family history of Arthritis or Joint problems? ☐ No ☐ Yes Describe:

REVIEW OF SYSTEMS

Are you currently having or have you had problems with:

			Describe all Yes Responses unless already described on previous pages
High Blood Pressure	☐ **No**	☐ **Yes**	_____
Diabetes	☐ **No**	☐ **Yes**	_____
Heart Disease	☐ **No**	☐ **Yes**	_____
Chest Pain	☐ **No**	☐ **Yes**	_____
Cancer	☐ **No**	☐ **Yes**	_____
Lungs, Breathing	☐ **No**	☐ **Yes**	_____
Digestion or Ulcers	☐ **No**	☐ **Yes**	_____
Blood Clots	☐ **No**	☐ **Yes**	_____
Bleeding problems	☐ **No**	☐ **Yes**	_____
Vision	☐ **No**	☐ **Yes**	_____
Hearing loss	☐ **No**	☐ **Yes**	_____
Swallowing	☐ **No**	☐ **Yes**	_____
Bowels	☐ **No**	☐ **Yes**	_____
Bladder - Urination	☐ **No**	☐ **Yes**	_____
Balance problems	☐ **No**	☐ **Yes**	_____
Numbness/tingling	☐ **No**	☐ **Yes**	_____
Blackout/fainting	☐ **No**	☐ **Yes**	_____
Depression or Anxiety	☐ **No**	☐ **Yes**	_____
Psychiatric problem	☐ **No**	☐ **Yes**	_____
Hepatitis	☐ **No**	☐ **Yes**	_____
HIV/AIDS	☐ **No**	☐ **Yes**	_____
Arthritis	☐ **No**	☐ **Yes**	_____

Patient Signature:_____ **Date:**_____
Reviewed By:_____ **Date:**_____