PATIENT HISTORY QUESTIONNAIRE

NAME: _____ AGE: _____ DATE OF INJURY: _____

REASON FOR TODAY'S VISIT: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? Yes ___ No ___ List any Medications that you are allergic to:

_____

PAST MEDICAL HISTORY Check YES or NO, do not leave any blanks.

CONDITION	YES	NO	CONDITION	YES	NO
Gallstones	Yes	No	Stroke	Yes	No
Pneumonia/Bronchitis	Yes	No	Liver Disease	Yes	No
Hypertension	Yes	No	Diabetes	Yes	No
Anemia	Yes	No	Emphysema/Asthma	Yes	No
Heart Attack	Yes	No	Heart Murmur	Yes	No
Tuberculoses	Yes	No	Hepatitis	Yes	No
Mitral Valve Prolapse	Yes	No	Arthritis	Yes	No
Cancer	Yes	No	Kidney Disease	Yes	No
Intestinal Disease	Yes	No	Weight Loss	Yes	No
Rheumatic Fever	Yes	No	Lung Disease	Yes	No
Blood Clots Lungs/Legs	Yes	No	Lupus	Yes	No
Other Disorders	Yes	No			

LIST ANY OTHER MEDICAL CONDITIONS THAT ARE NOT NOTED ABOVE:

_____

HAVE YOU HAD ANY SURGERIES? Yes ___ No ___ Please List _____

_____

_____

LIST ALL MEDICATION YOU ARE CURRENTLY TAKING: (Use the back of the page if needed)

MEDICATION **DOSE** **HOW OFTEN PER DAY** **REASON FOR TAKING**

_____

_____

_____

ARE YOU RIGHT OR LEFT HANDED? _____

DO YOU SMOKE? Yes ___ No ___ Pipe ___ Cigar ___

DO YOU CHEW TOBACCO? Yes ___ No ___ How much per day? _____

ARE YOU AN EX-SMOKER? Yes ___ No ___ If YES, when did you quit? _____

DO YOU DRINK ALCOHOL? Yes ___ No ___ Do you drink Daily? ___ Weekly? ___ Occasionally? ___

DATE OF LAST TETANUS SHOT: _____

FAMILY MEDICAL HISTORY

CURRENT **AGE** **AGE OF DEATH** **SIGNIFICANT MEDICAL PROBLEM**

MOTHER _____

FATHER _____

SIBLING _____