MEDICAL HISTORY QUESTIONNAIRE

NAME_____

DATE OF BIRTH_____

PRIMARY CARE PHYSICIAN_____

MEDICAL HISTORY: **Please read carefully and check all that apply**.

Do you have or have you ever had any of the following…?

□ **Arthritis / Rheumatologic Diseases**
- □ **Ankylosing Spondylitis**
- □ **Fibromyalgia**
- □ **Gout**
- □ **Osteoarthritis**
- □ **Rheumatoid Arthritis**
- □ **Spinal Stenosis**
- □**Other** _____

□ **Anemia**
□ **Allergies** _____
□ **Autoimmune Problems**
□ **Blood Clots (DVT, Pulmonary embolus)**
□ **Broken Bones / Fractures**
□ **Blood Disorders**
□ **Carpal Tunnel Syndrome**
□ **Cerebral Palsy**
□ **Circulation / Vascular Problems**
□ **Cancer: Type**_____
□ **Chest Pain / Angina**

□ **Chronic UTI / Bladder Infection**
□ **Developmental or Growth Problems**
□ **Degenerative Disc Disease**
□ **Disc Herniation**
□ **Depression**
□ **Diabetes**
□ **Frequent Urination**
□ **Hepatitis**
□ **Head Injury**
□ **Heart Problems** _____
□ **Heart Attack / MI**
□ **High Blood Pressure**
□ **Infectious Disease**
□ **Kidney Disease**
□ **Leukemia**
□ **Loss of weight in past year**
□ **Low Blood Sugar**
□ **Liver Disease**
□ **Lung / Breathing Problems**
□ **Multiple Sclerosis**

□ **Muscular Dystrophy**
□ **Migraine Headaches**
□ **Orthostatic Hypotension**
□ **Osteoporosis**
□ **Pacemaker**
□ **Parkinson's Disease / Syndrome**
□ **Peripheral Neuropathy**
□ **Polio**
□ **Pneumonia**
□ **Stomach Problems / Ulcers**
□ **Stroke / CVA / TIA**

□ **Shingles / Chickenpox**
□ **Skin Disease / Rash**
□ **Seizures / Epilepsy**
□ **Sinus Problems**
□ **Swelling of Legs**
□ **Thyroid Problems**
□ **Tuberculosis**
□ **Varicose Veins**
□ **Vertigo / Dizziness**
□ **Other Medical Problems**_____
_____

(OVER)

Have you had any of the following…

- ☐ **Abdominal / Laparoscopic Surgery**
- ☐ **Appendectomy**
- ☐ **Gall Bladder Removal**
- ☐ **Heart Surgery**
- ☐ **Cardiac Stents**
- ☐ **Pacemaker**

- ☐ **Hysterectomy**
- ☐ **Prostate Surgery**
- ☐ **Pulmonary Function Test**
- ☐ **Stress Test**

- ☐ **Echocardiogram**
- ☐ **Hemodialysis**

- ☐ **Biopsy**
- ☐ **Cesarean Section**

- ☐ **Other_____**

- ☐ **X-Ray**
- ☐ **CT Scan**
- ☐ **MRI**
- ☐ **EMG / Nerve Conduction Study**

- ☐ **Surgery for Bone Fracture Repair**
- ☐ **Hip Joint Replacement**
- ☐ **Knee Joint Replacement**
- ☐ **Shoulder Joint Replacement**
- ☐ **Carpal Tunnel Surgery**
- ☐ **Rotator Cuff Repair**
- ☐ **Meniscus Repair**

- ☐ **Cortisone Injection**
- ☐ **Epidural Injection**
- ☐ **Rhizotomy / Nerve Block**

- ☐ **Botox Injection**
- ☐ **Joint Manipulation**

Tobacco Use

- ☐ **Currently use tobacco products _____ packs per day**
- ☐ **Used in the past, but quit. How long ago? _____**
- ☐ **Never used tobacco products.**

Prescription / Non Prescription Medications (<u>You can attach a copy of your own list</u>)

Name	Dosage	Purpose	Prescribing Physician

Dietary or herbal supplements that you take:

Date Initially Completed _____ **Dates Reviewed_____**