PATIENT HISTORY & PHYSICAL MEDICAL QUESTIONAIRE

Patient Name: _____ **DOB:** _____ **Age:** _____

Social Security #: _____

ARE YOU DIABETIC? ___ - No ___ - YES If YES, what is your Hemoglobin A1c & Blood Sugar?

Hemoglobin A1c - _____ Blood Sugar - _____ When were these last checked? _____

PATIENT HEIGHT: _____ ft. _____ in. WEIGHT: _____ lbs. SHOE SIZE: _____

CHIEF COMPLAINT

Please describe your problem (include date of injury if applicable): _____

_____.

REVIEW OF CURRENT SYSTEMS (Please check all that apply)

I have reviewed all symptoms below and currently none apply - ☐

Respiratory

_____ - Cough _____ - Short of Breath _____ - Wheezing

Cardiovascular

_____ - Chest Pain _____ - Palpitations _____ - Swelling of Legs

Gastrointestinal

_____ - Abdominal Pain _____ - Change in Bowl Habits _____ - Heartburn

Musculoskeletal

_____ - Back Problems _____ - Deformities _____ - Joint Pain
_____ - Joint Stiffness _____ - Muscle Cramps _____ - Muscle Stiffness
_____ - Restricted Motion _____ - Weakness

Psychiatric

_____ - Behavioral Change _____ - Memory Loss

Neurological

_____ - Neuropathy

Endocrine

_____ - Change in Hair/Skin _____ - Heat/Cold Intolerance

PATIENT PAST MEDICAL HISTORY (Please **CHECK** all medically diagnosed past/current history that applies)

____ - ADHD/ADD ____ - Alcohol Dependent ____ - Alzheimer's ____ - Anemia
____ - Anxiety ____ - Arthritis ____ - Asthma ____ - BPH
____ - Back Problems ____ - Benign Prostatic Hyp. ____ - Bipolar ____ - Blind
____ - Blood Clots ____ - Breast Cancer ____ - Bronchitis ____ - CAD
____ - Congestive Heart Failure ____ - COPD ____ - Cancer What kind? _____ ____ - High Cholesterol
____ - Crohn's Disease ____ - Deaf ____ - Dementia ____ - Depression
____ - Diabetes ____ - Diag. Poor Circulation ____ - Drug Dependent ____ - Emphysema
____ - Epilepsy ____ - Fibromyalgia ____ - GERD ____ - Glaucoma
____ - Gout ____ - HIV ____ - Hard of Hearing ____ - Heart Disease
____ - Hemorrhoids ____ - Hepatitis ____ - Hypertension/HBP ____ - Irritable Bowl Syn
____ - Liver Disease ____ - Lupus ____ - MI/Heart Attack ____ - Macular Degen.
____ - Migraine ____ - OCD ____ - Paralysis ____ - Pneumonia
____ - Psychiatric Disorder ____ - Renal Stone ____ - Schizophrenia ____ - Sickle Cell
____ - Sleep Apnea ____ - Stroke ____ - TB ____ - TIA/Mini Stroke
____ - Thyroid Disease ____ - Tuberculosis ____ - Ulcer (GI)

DRUG ALLERGIES ☐ - No Drug Allergies to report

Please list any known Drug Allergies. _____

_____

MEDICATION ☐ - No Medications to report. ☐ - I provided a list

List all current medications or provide a list to be copied. (It is MANDATORY that we have this on file for all patients to be seen) _____

_____

_____

PREFERRED PHARMACY: _____ Location (Street/City/State): _____

FAMILY MEDICAL HISTORY ☐ - No Family Medical History to report

Has any close blood relative had any of the following (Please indicate relationship) Example: Mother, Father, Brother, Sister
Please circle whether that relative is Alive (A) or Deceased (D).

Cancer: _____(A / D) Diabetes: _____(A / D) Heart Trouble: _____(A / D)

Stroke: _____(A / D) Arthritis: _____(A / D) Kidney Disease: _____(A / D)

Blood Clots: _____(A / D) Tuberculosis: _____(A / D) Emphysema: _____(A / D)

SOCIAL HISTORY

Tobacco ☐ - No Tobacco history to report

Cigarettes:	Former / Never / Current	____ packs per day	For how long? _____
Cigars:	Former / Never / Current	____ packs per day	For how long? _____
Pipe:	Former / Never / Current	____ packs per day	For how long? _____
Chewing Tobacco:	Former / Never / Current	____ packs per day	For how long? _____
Dipping Tobacco:	Former / Never / Current	____ packs per day	For how long? _____

Alcohol ☐ - No Alcohol history to report

Beer	Social / Occasional / Light / Heavy	How often? _____	For how long? _____
Wine	Social / Occasional / Light / Heavy	How often? _____	For how long? _____
Hard Liquor	Social / Occasional / Light / Heavy	How often? _____	For how long? _____

EMPLOYMENT HISTORY ☐ - Employed (fill out section below) ☐ - Not Employed ☐ - Retired ☐ - Disabled

Employer: _____

Occupation/Job Title: _____

Duration on Job: ____ - 0-6 months ____ - 6-12 months ____ - 1-5 years ____ - 5+ years

Required Footwear: ____ Steel Toe ____ - Non-Slip Sole ____ - Rubber Boot ____ - None

SURGICAL HISTORY ☐ No known surgeries to report

Please list all **major** surgeries with estimated dates and the Doctor who performed the surgery.

_____

_____

_____

The information provided here is true to the best of my knowledge. I authorize release of any previous medical records including medication history by fax, mail, electronic or phone by either physician, hospital or pharmacy. Also, I hereby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition with x-ray, examination or photographs of infections as necessary.

X Patient Signature: _____ **Date:** _____