PATIENT HISTORY & PHYSICAL MEDICAL QUESTIONAIRE

Read and review each section below. Please complete each section in its entirety. If nothing in that section applies to you check the box that acknowledges that you have read and reviewed that section.

Incomplete paperwork will be returned for completion before being seen.

Patient Name: ______________________________ **DOB:** ______________ **Age:** ________

Social Security #: ______________________

PATIENT HEIGHT: ______ **ft.** ______ **in.** **WEIGHT:** __________ **lbs.** **SHOE SIZE:** __________

ARE YOU DIABETIC? ____ **- No** ____ **- YES** If YES, what is your Hemoglobin A1c & Blood Sugar?
Hemoglobin A1c - _______ Blood Glucose (Sugar) - ________ When were these last checked? ____________________

CHIEF COMPLAINT

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

____

REVIEW OF CURRENT SYMPTOMS (Please **CHECK** all that apply)

☐ - I have reviewed and acknowledged all symptoms below and currently none apply to me.

Respiratory
_____ - Cough
_____ - Short of Breath
_____ - Wheezing

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

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

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

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)

☐ - I have reviewed and acknowledged all symptoms below and none apply to me.

____ - ADHD/ADD
____ - Anxiety
____ - Back Problems
____ - Bronchitis
____ - Cancer What kind? _________
____ - Dementia
____ - Drug Dependent
____ - Glaucoma
____ - Heart Disease
____ - Irritable Bowl Syndrome
____ - Macular Degeneration
____ - Pneumonia
____ - Sickle Cell
____ - Ulcer (GI)
____ - Alcohol Dependent
____ - Arthritis
____ - Bipolar
____ - Coronary Artery Disease
____ - High Cholesterol
____ - Depression
____ - Epilepsy
____ - Gout
____ - Hemorrhoids
____ - Liver Disease
____ - Migraines
____ - Psychiatric Disorder
____ - Sleep Apnea
____ - Alzheimer's
____ - Asthma
____ - Blind
____ - Congestive Heart Failure
____ - Crohn's Disease
____ - Diabetes
____ - Fibromyalgia
____ - HIV
____ - Hepatitis
____ - Lupus
____ - OCD
____ - Renal Stone
____ - Stroke
____ - Anemia
____ - Benign Prost. Hyp.
____ - Blood Clots
____ - COPD
____ - Deaf
____ - Poor Circulation
____ - GERD
____ - Hard of Hearing
____ - Hypertension/HBP
____ - MI/Heart Attack
____ - Paralysis
____ - Schizophrenia
____ - Thyroid Disease

DRUG ALLERGIES ☐ - No Drug Allergies to report

Please list any known **Drug Allergies AND their reaction** to you. ____

____

____

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

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

____

____

____

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

FAMILY MEDICAL HISTORY ☐ - No Family Medical History to report / Unknown

Has any **blood** relative listed below had any of the following? Please circle which medical diagnosis applies to each member. Please circle whether that relative is Alive (A) or Deceased (D).

Father (A / D):	Arthritis	Blood Clots	Cancer	COPD	Diabetes	Heart Disease	Kidney Disease	Stroke
Mother (A / D):	Arthritis	Blood Clots	Cancer	COPD	Diabetes	Heart Disease	Kidney Disease	Stroke
Brother (A / D):	Arthritis	Blood Clots	Cancer	COPD	Diabetes	Heart Disease	Kidney Disease	Stroke
Sister (A / D):	Arthritis	Blood Clots	Cancer	COPD	Diabetes	Heart Disease	Kidney Disease	Stroke

SOCIAL HISTORY Please **circle** the appropriate selections.

Tobacco ☐ - No Tobacco history to report

Cigarettes:	Former / Never / Current	____ pack(s) a day for _____ years.
Cigars:	Former / Never / Current	____ cigar(s) a day for _____ years.
Pipe:	Former / Never / Current	____ (pouch / tin) a day for _____ years.
Chewing Tobacco:	Former / Never / Current	____ (pouch / tin / pinch / sachet) packs a day for _____ years.
Dipping Tobacco:	Former / Never / Current	____ (pouch / tin / pinch / sachet) packs a day for _____ years.
Vape:	Former / Never / Current	

Alcohol ☐ - No Alcohol history to report

Beer:	Social / Occasional / Light / Heavy	I average ____ (glass / bottle / can) per (day / week / month).
Wine:	Social / Occasional / Light / Heavy	I average ____ (glass / bottle) per (day / week / month).
Hard Liquor:	Social / Occasional / Light / Heavy	I average ____ (drink / bottle / pint / quart) per (day / week / month).

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

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 MAJOR surgeries to report

Please list all **MAJOR** surgeries. Please add estimated month/year and the Doctor who performed the surgery as able.

____

____

____

The information provided here is true to the best of my knowledge. I authorize the 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:** _________________________