Name:
DOB:
Age:
Chart: Date:

PATIENT QUESTIONNAIRE
INITIAL EVALUATION

Family/Primary Doctor: _____ Phone: _____

Emergency Contact: Name _____ Phone: _____

Who referred you to our office (name & address please)? _____

INSTRUCTIONS: Please provide the following information, in detail. This information is required for billing purposes. Failure to provide this information may result in your insurance company denying payment.

Age: _____ Sex: _____ Height: _____ Weight: _____ Marital Status: _____

Occupation: _____ Dominant Hand: Right _____ Left _____

What are you seeing us for? _____

What date did this start/happen? _____

Have you seen a doctor in the past for this problem or injury? Yes / No (If yes, who/when) _____

What treatment have you had for this problem/injury? _____

Is this an injury related to a : (circle one)

Work accident? Yes / No Military accident? Yes / No Auto accident? Yes / No

Other? Yes / No (Please Explain) _____

If you said yes to any of the above, please complete the following:

Where were you when this injury happened? (What specific location, i.e. in house, store, parking lot)

What were you doing at the time of the injury? (What specific activity, i.e. walking through door) _____

What caused the injury? (i.e. struck nose on door, fell struck knee on asphalt) _____

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TELL US ABOUT YOURSELF AND YOUR PAST MEDICAL HISTORY:

Circle any of the medical problems listed below that you have now:

(A) I have no known medical problems.
(B) Hypertension
(C) Coronary artery disease
(D) Peripheral vascular disease
(E) Adult onset diabetes
(F) Childhood onset diabetes
(G) Past heart attack
(H) Asthma
(I) Ulcers/GERD
(J) Hepatitis/Liver Disease
(K) Cancer _____
(L) High Cholesterol
(M) Kidney disease
(N) Seizure disorder
(O) Thyroid disease
(P) Stroke
(Q) COPD/Lung problem
(R) Immune disorder/Lupus/Rheumatoid Arthritis
(S) Overweight
(T) Osteomyelitis (Bone Infection)
(U) Blood Clot (DVT)
(V) Osteoporosis
(W) Other (Specify): _____

Circle any surgeries listed below you may have had. Indicate the year of the surgery:

(A) No previous surgeries _____
(B) Foot/Ankle Surgery _____
(C) Joint Surgery _____
(D) Bypass / open heart _____
(E) Gallbladder _____
(F) Hernia repair _____
(G) Hysterectomy _____
(H) Spinal Surgery _____
(I) Mastectomy _____
(J) Hand Surgery _____
(K) Prostate surgery _____
(L) Other (Specify): _____

Any previous broken bones: _____

Blood transfusion: Yes / No Year: _____

Circle anything listed below to which you are allergic:

(A) No known allergies
(B) Penicillin
(C) Tetracycline
(D) Sulfa
(E) Morphine
(F) Erythromycin
(G) Codeine
(H) Iodine/Betadine
(I) Radiographic Dyes
(J) Adhesive Tape
(K) Latex
(L) Other (Specify): _____

What medications are you currently taking? Please include both prescription and non-prescription medications.

Medications	Dose	# Times a Day

CONTINUE ON NEXT PAGE, IF SPACE NEEDED

Name:
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How much alcohol do you consume?

(A) No, I'm not a drinker
(B) Yes, less than 1 drink / week
(C) Yes, 2 - 7 drinks / week
(D) Yes, greater than 8 drinks / week

Do you now, or have you ever used tobacco products ?

(A) Yes I am currently a tobacco user.
I smoke (circle one) 1 2 3 _____ packs/day _____ chew _____ per day
I have used for _____ years

(B) No, but I used to smoke Quit Date _____ I smoked for _____ years ____ packs / day

(C) No, I have never used tobacco products.

Do you now, or have ever used drugs?

(A) Recreational
(B) Cocaine
(C) Marijuana
(D) Other (Specify): _____

Has anyone in your immediate family ever had any of the following? Circle the illness that apply.

(A) None known
(B) Cancer
(C) Leukemia
(D) Stroke
(E) Hypertension
(F) Coronary artery disease
(G) Rheumatic fever
(H) Diabetes
(I) Hypothyroidism
(J) Colitis
(K) Bleeding tendency
(L) Asthma
(M) Tuberculosis
(N) Seizure disorder
(O) Alcoholism
(P) Other (Specify): _____

Have you ever had a blood clot? Yes No

Have you ever been told you had MRSA or VRE? Yes No Latex Allergy? Yes No

MEDICATIONS NOT LISTED ON PREVIOUS PAGE, OR OTHER NOTES

Medications	Dose	# Times a Day

Name:
DOB:
Age:
Chart: Date:

Review of Systems

Do you now or have you had (within 30 days) any problems related to the following systems? Circle Yes or No.
Please explain any Yes answers in space provided.

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Other		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other		

Cardiovascular

Chest Pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Swollen glands	Y	N
Blood clotting problem	Y	N
Other		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other		

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other		

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N
Other		

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other		

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Weight Loss	Y	N

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other		

Other Health Issues:

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.