HEALTH HISTORY

New Patient History Questionnaire

History of Present Illness:

1. What is the reason for your visit today?_____
2. How long have you had this problem?_____
3. Is this an injury?_____

    Work related?_____

    Car accident?_____

4. What types of symptoms are you having?_____

5.Does anything or any activity make the problem worse?

6. Does anything or any activity make the problem better?

7. How often are you experiencing symptoms?

8. What treatment have you received for this problem so far?(medications, therapy, surgery, etc)

Constitutional

Weight loss or gain ☐ Y ☐ N
Fevers or chills ☐ Y ☐ N
Fatigue ☐ Y ☐ N
Unable to sleep ☐ Y ☐ N

Eyes

Visual Loss ☐ Y ☐ N
Double Vision ☐ Y ☐ N
Blurred Vision ☐ Y ☐ N
Cataracts ☐ Y ☐ N
Glaucoma ☐ Y ☐ N

Cardiovascular

Hypertension ☐ Y ☐ N
Chest Pain ☐ Y ☐ N
Shortness of breath ☐ Y ☐ N
Leg Swelling ☐ Y ☐ N
Low blood pressure ☐ Y ☐ N
Heart Murmur ☐ Y ☐ N
Heart Failure ☐ Y ☐ N

Ear, Nose, Mouth and Throat

Sinus ☐ Y ☐ N
Hearing ☐ Y ☐ N
Balance Problems ☐ Y ☐ N
Sleep Apnea ☐ Y ☐ N
Sore Throat ☐ Y ☐ N
Ringing in the ears ☐ Y ☐ N
Dizziness ☐ Y ☐ N

Endocrine

Diabetes ☐ Y ☐ N
Thyroid ☐ Y ☐ N

Respiratory

Emphysema ☐ Y ☐ N
COPD ☐ Y ☐ N
TB ☐ Y ☐ N
Chronic cough ☐ Y ☐ N
Bronchitis ☐ Y ☐ N
Pneumonia ☐ Y ☐ N

Gastrointestinal

Ulcer ☐ Y ☐ N
Hepatitis ☐ Y ☐ N
Constipation ☐ Y ☐ N
Diarrhea ☐ Y ☐ N
Bowel Incontinence ☐ Y ☐ N
Hiatal Hernia ☐ Y ☐ N
Rectal Bleeding ☐ Y ☐ N

Genitourinary

Kidney stones ☐ Y ☐ N
Urinary urgency ☐ Y ☐ N
Urinary incontinence ☐ Y ☐ N
Sexual dysfunction ☐ Y ☐ N
Vaginal Bleeding ☐ Y ☐ N
Painful urination ☐ Y ☐ N
Blood in urine ☐ Y ☐ N

Musculoskeletal

Low back pain ☐ Y ☐ N
Neck Pain ☐ Y ☐ N
Joint Pain ☐ Y ☐ N
Joint Swelling ☐ Y ☐ N

Integumentary & Breast

Rash or skin disorder ☐ Y ☐ N
Cysts ☐ Y ☐ N
Tumor ☐ Y ☐ N
Melanoma ☐ Y ☐ N

Neurological

Headache ☐ Y ☐ N
Seizure ☐ Y ☐ N
Loss of consciousness ☐ Y ☐ N
Memory Loss ☐ Y ☐ N
Weakness ☐ Y ☐ N
Trouble with walking ☐ Y ☐ N
Numbness ☐ Y ☐ N
Falls ☐ Y ☐ N
Concussion ☐ Y ☐ N

Psychiatric

Depression ☐ Y ☐ N
Anxiety ☐ Y ☐ N

Hematologic/Lymphatic

Blood disorder ☐ Y ☐ N
Leukemia ☐ Y ☐ N
Sickle cell ☐ Y ☐ N
HIV ☐ Y ☐ N

Allergenic/Immunologic

Rheumatoid Arthritis ☐ Y ☐ N
Lupus ☐ Y ☐ N
Allergies ☐ Y ☐ N
Fibromyalgia ☐ Y ☐ N

Past Medical History

List all current and past medical problems as well as major illness you have had in the past with approximate dates.

1._____

2._____

3._____

4._____

5._____

6._____

Past Surgical History

1._____

2._____

3._____

4._____

5._____

6._____

Current Regular Medications:

_____

_____

_____

_____

_____

_____

Pain medications, muscle relaxers:

_____

Drug and Food Allergies:

Please list any known drug or food allergies.

Family History

Please list all current medical problems and current age of the following family members. If deceased Please list cause of death and approximate age of death.

Father_____Mother_____

Brothers_____
Sisters_____

Children_____

Social History

Are you Single _____Married_____Divorced_____Widowed_____?
What is your highest level of education? _____
What is your occupation?_____
Are you disabled?_____

Do you smoke ?_____ If yes ,how much and for how long?_____
If you quit , when did you quit?_____

Do you drink alcohol?____ If yes ,what do you drink and how much?_____

Have you used illicit drugs?_____

Have you been in rehab?_____

Injury History:

Have you suffered any injuries ?____ If yes ,please describe._____

Have you been in any car accidents ? _____If yes, how many and were there any injuries?_____

On the job injuries:

Have you been injured on the job?_____If yes, how and when were you injured.

Have injuries resolved?

Name of person completing this form._____

Reviewed by :_____Date:_____

Date of visit :_____

Patient Name:_____Age:_____