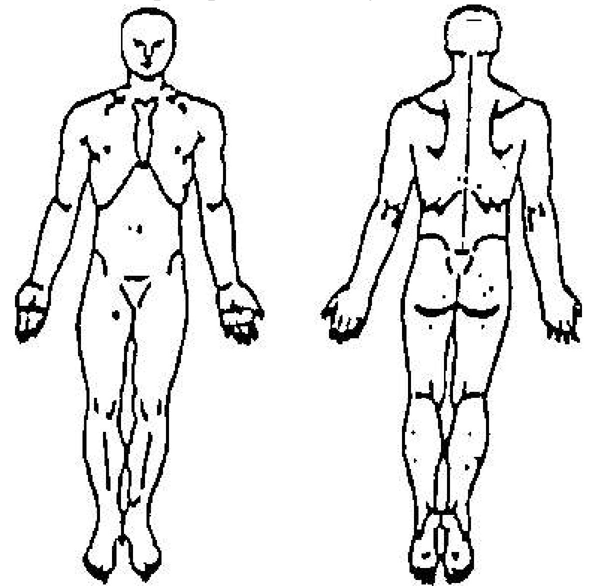
MEDICAL HISTORY QUESTIONNAIRE

NAME ____ TODAY'S DATE ___________________

AGE__________ WEIGHT __________ HEIGHT ____________OCCUPATION ____________________

Please draw pain pattern on body chart below:



1. Where is your pain?

____

2. When did it start?

____

3. Is your pain the result of an injury? If yes. describe briefly.

____

4. Is your pain: constant or intermittent

5. Describe your pain: sharp dull achy deep burning throbbing

Rank your symptoms from 1-10, 1 being none, and 10 being unbearable

At rest_______ During activities_______

6. What activities make your pain worse? __________________

7. What can you do to relieve your pain? __________________

8. Does your condition affect your sleep? Yes or No. If yes, can you go back to sleep? __________________

9. How do you feel in the morning? Stiff Sore Fine

10. Since this problem started what tests have been done? X-ray MRI CT Scan EMG
Have you had any lab work done? Yes or No

11. Have you had anything similar to this condition? ____

12 List all medications which you are taking ____

____

13. Do you exercise? If yes, please describe ____

____

Is there anything else that you would like to add? ____

____

General Medical History

1. In the last three months have you had any of these symptoms

______ fever	______ diarrhea	______ weight loss	______ unexplained sweating
______ night sweats	______ nausea	______ abdominal pain	______ vomiting
______ fatigue	______ dizziness	______ fainting	

2. Do you become short of breath easily? Yes or No

3 Do you experience leg cramps? Yes or No

4 Do you have headaches? Yes or No

5 Do you have symptoms before, during or after eating) Yes or No

6 Has your bowel or bladder function changed' Yes or No
(i.e. pain, color)

7 Are you pregnant? Yes or No

8. Have you had a joint replacement? Yes or No

9. Have you been treated for cancer? Yes or No

10. Do you have chest pain? Yes or No

Have you had a history of/or do you have the following:

______ Tuberculosis	______ Hernia	______ Diabetes	______ High Blood Pressure
______ Bursitis	______ Epilepsy	______ Heart Disease	______ Rheumatoid arthritis
______ Lung Disease	______ Infection	______ Intestinal Disorder	______ Liver or Gallbladder problems