

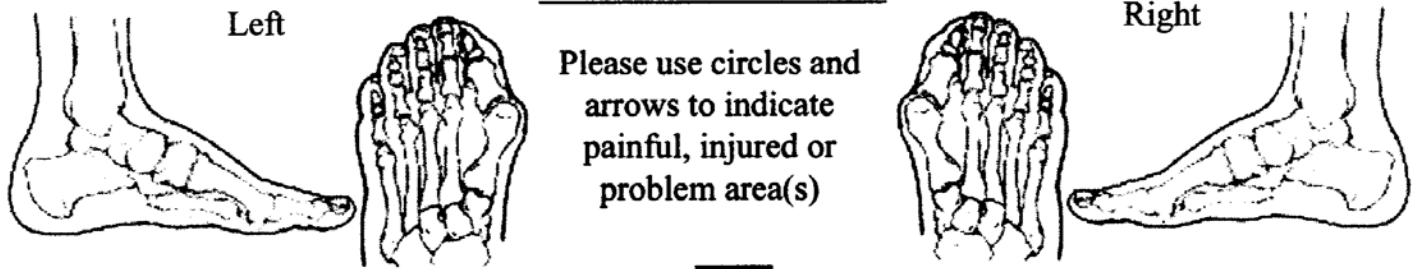
PATIENT INITIAL HISTORY QUESTIONNAIRE

Everything I answer is true, complete, and correct to the best of my knowledge. Failure to provide a truthful and complete medical history may result in serious complications, harm, or discharge from this office. You may be required to provide more medical information so that we can give you the best care and assessment.

Patient Name: _____ Date: _____

Date of Birth: _____ (Office use only) MR# _____

Family/Primary Doctor: _____ Who referred you to us? _____



REASON FOR VISIT: _____

HOW LONG HAS THIS PROBLEM BEEN PRESENT? _____

THE PROBLEM IS: Improving Getting Worse Not changing

THE PAIN SCALE IS: 0 1 2 3 4 5 6 7 8 9 10 (worst)

Other Physician's you have seen for this problem: _____

ARE YOU TAKING ANY MEDICATION FOR THIS PROBLEM? _____

DOES THE MEDICATION HELP? Yes No

WHAT AGGREGATES THE PROBLEM? _____

WHEN IS THE PROBLEM WORSE? Morning End of day While sleeping

ALLERGIES: No Known Drug Allergies Name of Drugs: _____

Ongoing Medical Problems: No known medical problems

- | | | |
|--------------------------------------------|---------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> CAD | <input type="checkbox"/> PVD |
| <input type="checkbox"/> Adult Diabetes | <input type="checkbox"/> Childhood Diabetes | <input type="checkbox"/> Past heart attack |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hepatitis A/ B / C |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Seizure disorders | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> COPD/Lung dz | <input type="checkbox"/> Immune Disorder | <input type="checkbox"/> Overweight |
| <input type="checkbox"/> Osteomyelitis | <input type="checkbox"/> DVT | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Leg cramps | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Other: _____ |

Major Medical Event or Hospitalization for:

PAST SURGICAL HISTORY: No previous surgeries

- Hysterectomy Appendectomy Lumbar laminectomy
- Cataract extraction Mastectomy By-pass / open heart
- Tonsillectomy Gall bladder Prostate surgery
- Hernia repair Foot Surgery Other: _____

FAMILY HISTORY:

PREVENATIVE CARE:

NUTRITIONAL HISTORY:

DEVELOPMENTAL/PEDIATRIC HISTORY: Normal

MEDICATIONS: None

NAME	DOSE

THE FOLLOWING CHECK MARKS INDICATE ABNORMALITIES:

I HAVE NO PROBLEMS

- blurred vision headaches stiffness difficulty swallowing
- chest pain palpitations SOB coughing
- nausea vomiting frequent urination
- leg cramping resting pain in toes swelling
- arthritis joint pain total joint implant

Patient or Guardian's Signature / Date