MEDICAL QUESTIONNAIRE

PATIENT'S NAME _____
First M.I. Last

REASON FOR TODAY'S VISIT: _____ **FIRST DATE OF ONSET**: _____

DID THIS INJURY OCCUR AT WORK? ☐ Yes ☐ No

If yes, please describe how the injury occurred: _____

HEIGHT: **WEIGHT**: **PRIMARY CARE DOCTOR**:

PAST MEDICAL HISTORY (Please √ if you have any of these in the past)

☐ AIDS/HIV	☐ Fracture History, please specify: _____	☐ Osteoporosis
☐ Anemia		
☐ Arthritis		☐ Peripheral Vascular Disease/Poor Circulation
☐ Auto-immune Disease	☐ Fungal Infections	☐ Psoriasis
☐ Bleeding Disorders	☐ Gout	☐ Rheumatic
☐ Breathing problems/Lung Disorders	☐ Heart Disease	☐ Sciatica/Back Problems
	☐ Hepatitis	
☐ Cancer, please specify: _____	☐ High Blood Pressure	☐ Seizure Disorder
	☐ High Cholesterol	☐ Skin Cancer
☐ Cellulitis	☐ Gastrointestinal Reflux/Ulcers/Bleed	☐ Stroke
☐ Congestive Heart Failure	☐ Kidney Disease/Dialysis	☐ Thyroid Problems
☐ Deep Vein Thrombosis	☐ Liver Disease	☐ Varicose Veins
☐ Diabetes: ☐ Diet ☐ Oral ☐ Insulin	☐ Neuropathy	☐ Warts
☐ Other:		

CURRENT MEDICATIONS ☐ None ☐ I take the following prescription or over the counter medications:

_____ _____ _____

ALLERGIES

☐ No known allergies

☐ I have the following allergies: ☐ Penicillin ☐ Shellfish ☐ Sulfa ☐ Codeine ☐ Iodine ☐ Aspirin/NSAIDs

☐ Adhesive/tape ☐ Cortisone ☐ Local anesthetics ☐ Other, please specify: _____

SURGICAL HISTORY/HOSPITALIZATIONS

☐ None

☐ I have had the following surgeries or hospitalizations in the past:

_____ Year: _____ _____ Year: _____ _____ Year: _____

_____ Year: _____ _____ Year: _____ _____ Year: _____

Any complications with any of the above surgeries?

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes, everyday (5-7 days /week) ☐ Yes, occasionally/socially ☐ No/Rarely

Substance abuse:

☐ Yes, I have a current substance abuse problem. Please specify: _____

☐ Yes, I had a past substance abuse problem. Please specify: _____

☐ No, I have never had a substance abuse problem.

Do you exercise regularly? ☐ Yes, I do the following regular exercise: _____

☐ No, I do not exercise regularly.

_____ _____

Patient/Parent/Guardian **Date**

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