



Medical History Questionnaire—Update

DATE: _____
Name: _____ **Age:** _____ Right-Handed Left Handed
Referring Physician: _____ **Primary Care Physician (PCP):** _____
Preferred Pharmacy: _____ **Phone:** _____
Pharmacy Address: _____ **City:** _____

REASON FOR VISIT? _____ **NEW PROBLEM** Yes No.

MEDICATION HISTORY- Please list all current medication (including over the counter medications) Please feel free to attach additional sheets if necessary.

Medication	Indication	Dose	Prescribing Physician

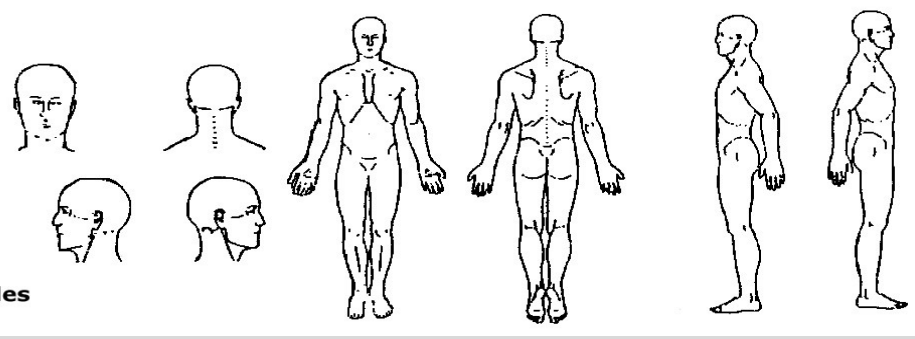
Pain Analogue Scale:

No Pain	Minimal	Moderate	Intense	Emergency
0	1 2 3	4 5 6	7 8 9	10

Pain Diagram: Please rate your pain: Today: ___/10 Average day: ___/10 Good Day: ___/10 Bad Day ___/10

- Please mark the areas of your pain. You may use the key to indicate different kinds of pain sensations.
- Please number each painful area in order of the

- Key:**
- - shooting
 - /// - stabbing
 - xxx - aching
 - 000 - throbbing
 - - pins & needles
 - *** - burning



REVIEW OF SYSTEMS

- CONSTITUTIONAL** Fever Weight Loss Weight Gain Weakness Fatigue Difficulty Sleeping Chills Night Sweats
- EYES** Visual Problems Glaucoma
- HENT** Headaches Sinus Problmes Hearing Problems Sleep Apnea
- CARDIOVASCULAR** Heart Trouble Swelling of feet Hypertension Lower Extremity Swelling
- RESPIRATORY** Cough Shortness of Breath
- GASTROINTESTINAL** Liver Disease Hepatitis Gall Bladder Problems Reflux Bowel Problems Consitpation Diarrhea
- GENITOURINARY** Kidney Stone Kidney Disease Bladder Problems Blood in Urine Reduced Libido (desire for sex)
- INTEGUMENT** Dry Skin Rashes
- NEUROLOGICAL** Seizures Stroke Peripheral neuropathy Numbness Memory or concentration difficulties Loss of Balance Falls Head Injuries
- MUSCULOSKELETAL** Neck Pain Shoulder Pain Elbow Pain Wrist/Hand Pain Carpal Tunnel Syndrome Low Back Pain Hip Pain Knee Pain Foot/Ankle Pain Gout
- ENDOCRINE** Thyrod Problem Diabetes Excessive Thirst
- PSYCHIATRIC** Depression Anxiety Anger Guilt
- HEME-LYMPH** Easy Bruising HIV Exposure Bleeding Problems
- ALLERGIC-IMMUNOLOGIC** Seasonal Allergy Allergies Anaphylactic (Severe) Medication Allergies Anaphylactic (severe) Reaction to Bee Stings

ALLERGIES

NO KNOWN DRUG ALLERGIES Iodine Contrast Dye (IVP) Latex

Please list drug allergies, type or reaction and onset date, if known: _____

Any severe allergic Reactions (Anaphylaxis) to anything? Yes No If yes, to what, type of reaction and onset date:

MEDICAL HISTORY Please Circle: P - PAST HISTORY or C - CURRENT PROBLEM.

	DATE	STATUS		DATE	STATUS
Alzheimer's Disease/Dementia		P C	HIV/Aids Disease		P C
Anxiety		P C	Hypertension (High Blood Pressure)		P C
Asthma/COPD		P C	Irritable Bowel Syndrome (IBS)		P C
Atrial Fibrillation		P C	Kidney Disease		P C
Blood Disorder: _____		P C	Lupus		P C
Cancer: Type _____		P C	Lyme Disease		P C
Cardiac Pacemaker		P C	Marfan Syndrome		P C
Chronic Regional Pain Syndrome		P C	Migraines		P C
Depression		P C	Osteopenia/Osteoporosis		P C
Ehlers Danlos Syndrome		P C	Parkinson's Disease		P C
Gastric Ulcer		P C	Peripheral Neuropathy		P C
Glaucoma		P C	Peripheral Vascular Disease		P C
Head Injury or Concussion		P C	Rheumatoid Arthritis		P C
Heart Disease (Coronary Artery Disease)		P C	Seizure Disorder		P C
Heart Failure		P C	Shingles		P C
Hernia		P C	Sleep Apnea		P C
High Cholesterol		P C	Stroke (CVA)		P C

Additional Medical History:

SURGICAL HISTORY

No Pertinent Past Surgical History

Please list all surgeries: _____

SOCIAL HISTORY

Able to care for self

Able to drive

Climbs stairs daily

Regular exercise

Alcohol:

Denies use Occasional use

more than 15 drinks/week

Marital status:

Single Married

Divorced/separated Widow/Widower

Other important social issues: _____

Smoking: Denies

Admits to smoking (____ packs/day) Former Smoker: Date Quit: _____

Substance Abuse : Denies

In past (including alcohol)

Use of illegal drugs in the last year

Work status:

Student

Does not work outside the home: Disabled Retired

Works outside the home

Occupation: _____