PATIENT MEDICAL HISTORY QUESTIONNAIRE

Security Question: Choose check the question of your choice and then provide the verification answer.

( ) What is the name of your favorite pet? ( ) In what city were you born? ( ) What high school did you attend?
( ) What is your mother's maiden name? ( ) What is your favorite movie? ( ) On what street did you grow up?
( ) What was the make of your first car? ( ) When is your anniversary? ( ) What is your favorite color?

Verification Answer: _____

Do you currently smoke tobacco of any kind? ( ) Yes ( ) Former smoker ( ) Never been a smoker
If yes, how often do you smoke: ( ) Currently every day smoker ( ) Current sometimes smoker
If yes, what is your level of interest in quitting smoking?
No Interest (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Very Interested

MEDICAL CONDITIONS

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Acid Reflux			COPD/Emphysema			Lupus		
AIDS or HIV			Type I Diabetes			Migraines		
Anemia			Type II Diabetes			Prostate Disease		
Arthritis			Heart Disease			Fibromyalgia		
Blood Clots/DVT			Hepatitis			Depression		
High Cholesterol			High Blood Pressure			Scoliosis		
Bronchitis/Pneumonia			Inflammatory Bowel			Seizures		
Cancer			Kidney Disease			Sleep Apnea		
Thyroid Disease			Ulcers			CPAP or BIPAP used for Apnea?		
Transfusions			Urinary Incontinence			Stroke		

SYMPTOM CHECKER (Check all present symptons)

HEAD:
( ) Headache
- ( ) sinus (allergy)
- ( ) entire head
- ( ) back of head
- ( ) forehead
- ( ) temples
- ( ) migraine

( ) Head feels heavy
( ) Loss of memory
( ) Light-headedness
( ) Fainting
( ) Light bothers eyes
( ) Blurred vision
( ) Double vision
( ) Loss of vision
( ) Loss of balance
( ) Dizziness
( ) Loss of hearing
( ) Pain in ers
( ) Ringing in ears
( ) Buzzing in ears

NECK:
( ) Pain in neck
( ) pain with movement
- ( ) Forward
- ( ) Backward
- ( ) Turn to left
- ( ) Turn to right
- ( ) Bend to left
- ( ) Bend to right

( ) Pinched nerve
( ) Neck feels out of place
( ) Muscle spasms
( ) Grinding sound
( ) Popping sound
( ) Arthritis in neck

SHOULDERS:
( ) Pain in shoulder joint (R - L)
( ) Pain across shoulders
( ) Brusitis (R – L)
( ) Arthritis (R – L)
( ) Cannot raise arm
- ( ) above shoulder level
- ( ) over head

( ) Tension in shoulders
( ) Pinched nerve (R – L)
( ) Muscle spasms in shoulders

ARMS & HANDS:
( ) Pain in upper arm
( ) Pain in elbow
( ) Movement aggravated
( ) Tennis elbow
( ) Pain in forearm
( ) Pain in hands
( ) Pain in fingers
( ) Sensation of pins & needles in arms
( ) Pins & needles in fingers
( ) Numbness in arms (R – L)
( ) Numbness in fingers (R – L)
( ) Fingers go to sleep
( ) Hands cold
( ) Swollen joints in fingers
( ) Sore joints in fingers
( ) Arthritis in fingers
( ) Loss of grip strength

MID-BACK:
( ) Mid-back pain _____location
( ) Pain between shoulder blades
( ) Sharp stabbing
( ) Dull ache
( ) Pain from front to back
( ) Muscle spasms
( ) Pain in kidney area

CHEST:
( ) Chest pain
( ) Shortness of breath
( ) Pain around ribs
( ) Breast pain
( ) Dimpled/orange peel breast

ABDOMEN:
( ) Nervous stomach
( ) Foods can't eat _____
( ) Nausea
( ) Gas
( ) constipation
( ) Diarrea
( ) Hemorroids

LOW BACK:
( ) Low back pain
- ( ) upper lumbar
- ( ) lower lumbar
- ( ) sacroiliac

( ) Low back pain is worse when
- ( ) working
- ( ) stooping
- ( ) standing
- ( ) sitting
- ( ) bending
- ( ) coughing
- ( ) lying down/sleeping
- ( ) walking

( ) Pain relieved when _____
( ) slipped disk
( ) low back feels out of place
( ) muscle spasms
( ) arthritis

HIPS, LEGS & FEET:
( ) Pain in buttocks (R – L)
( ) Pain in hip joint (R – L)
( ) Pain down leg (R – L)
( ) Pain down both legs

HIPS, LEGS & FEET, CONT'D:
( ) Knee pain
- ( ) Inside
- ( ) Outside

( ) Leg cramps
( ) Cramps in feet (R – L)
( ) Pins & needles in leg (R – L)
( ) Numbness of feet (R – L)
( ) Numbness of toes
( ) Feet feel cold
( ) Swollen ankles (R – L)
( ) Swollen feet (R – L)

WOMEN ONLY:
( ) Menstrual pain _____(where)
( ) Cramping
( ) Irregularity
( ) Cycle _____ days
( ) Birth control type _____
( ) Hysterectomy
( ) Genital cancer _____
( ) Discharge _____color
( ) Tumors
( ) Abortions
( ) Menopause

MEN ONLY:
( ) Urinary frequency
( ) Difficulty in starting
( ) Night urination
( ) Prostate pain/swelling

GENERAL
( ) Nervousness
( ) Irritable
( ) Depressed
( ) Fatigue
( ) Normal sleep ____hrs/night
( ) Loss of sleep ____ hrs/night
( ) Coffee& tea ____cups/day

Patient Signature _____ Date _____