

PATIENT HISTORY QUESTIONNAIRE

Your answers on this form will help your provider understand your medical concerns and conditions better. This form will be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. **Thank you!**

TODAY'S DATE _____

NAME _____ AGE _____ DOB _____

REASON FOR TODAY'S VISIT: _____

Approximate date symptoms started: _____

ARE YOU ALLERGIC TO ANY MEDICINES? YES NO If yes, please list: _____

IS VISIT RELATED TO WORK OR AUTO INJURY? YES NO Date of injury _____

PLEASE LIST ALL PAST OPERATIONS AND SERIOUS ILLNESSES:

<u>Operation or Illness</u>	<u>Month and Year</u>	<u>City, State</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

<u>Recent x-rays, labs or tests</u>	<u>Date</u>	<u>Facility/Doctor</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

<u>Medicine</u>	<u>Dose</u>	<u>Frequency</u>	<u>For What Illness?</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DO YOU CURRENTLY TAKE: HERBAL SUPPLEMENTS, SUCH AS GINGKOBA OR ST. JOHNS WORT OR ASPIRIN PRODUCTS? YES NO

If yes, please list _____

SOCIAL HISTORY:

Do you smoke? YES NO If yes, how much? _____

Do you drink alcohol? YES NO If yes, how much? _____

Previous steroid use? YES NO If yes, how much? _____

FAMILY HISTORY:

	<u>Age</u>	<u>Diseases/Conditions</u>	<u>If Deceased, Cause of Death</u>
FATHER	_____	_____	_____
MOTHER	_____	_____	_____
SIBLINGS	_____	_____	_____
SPOUSE	_____	_____	_____
CHILDREN	_____	_____	_____