

Comprehensive History Questionnaire

Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____ Occupation: _____

Referred to our office by: _____

Chief Complaint: (brief description of your current orthopaedic problem) Please Circle: **Left, Right, or Both**

History of Present Illness: (answer these questions regarding your current problem(s) only)
(may indicate on the pictogram below)

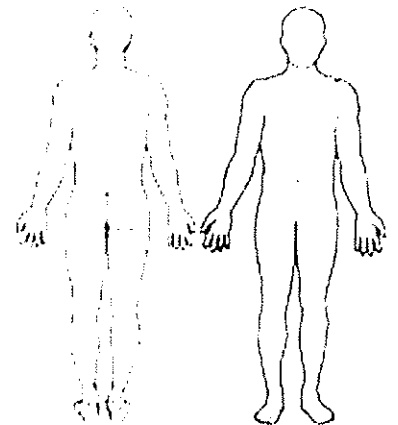
What symptoms are you experiencing? _____

How long have you had this problem? _____

Have you had similar pains in the past?
 yes no If yes, when? _____

How did it happen? _____

Injury? yes no If yes, give date: _____
Where did it occur? _____



Work related? yes no If yes, give date of injury? _____
How many work-days have you missed? _____
Are you working now? yes no
Have you had previous work-related injuries? yes no If yes, when? _____

How severe is this for you? (place an "X" on the line below)
No pain (0)------(10) Worst pain of your life

What makes it worse? (eg. sitting, standing, walking, exercise, coughing/sneezing) _____

What makes it better? (eg. lying, sitting, standing, walking, exercise, pain pills) _____

Give previous treatment for this problem? (eg. emergency room, physical therapy, chiropractic or other alternative treatments)

Have you had any of the following diagnostic studies for your current problem?

Diagnostic X-rays	<input type="checkbox"/> yes <input type="checkbox"/> no	Date: _____
CT (computed tomography)	<input type="checkbox"/> yes <input type="checkbox"/> no	Date: _____
MRI (magnetic resonance imaging)	<input type="checkbox"/> yes <input type="checkbox"/> no	Date: _____
Myelogram	<input type="checkbox"/> yes <input type="checkbox"/> no	Date: _____
Epidural Steroid / Facet Block injection	<input type="checkbox"/> yes <input type="checkbox"/> no	Date: _____
EMG (electromyogram) / NCV (nerve conduction velocity)	<input type="checkbox"/> yes <input type="checkbox"/> no	Date: _____

Review of Systems: (please indicate yes or no)

Constitutional

fever Y N
weight change Y N

Eyes

visual change Y N

Ears, Nose, Mouth

hearing change Y N
sinus problems Y N
dental problems Y N

Cardiovascular

chest pain Y N
hypertension Y N
shortness of breath Y N

Respiratory

tuberculosis Y N
pneumonia Y N
asthma Y N

Endocrine

diabetes Y N
if Yes – Insulin dependent? Y N
thyroid problem Y N

Gastrointestinal

nausea/vomiting Y N
blood in stool Y N

Genitourinary

urinary infections Y N
incontinence Y N

Skin

infections Y N
lesions/ulcers Y N

Neurologic

seizures Y N
paralysis Y N

Psychiatric

depression Y N

Hematologic

blood clots Y N
bleeding Y N

Past Medical History: (please list those medical conditions/illnesses). **This does not include surgeries. (Lifetime)**

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Past Surgical History: (please list prior surgeries, especially those related to your current problem) **(Lifetime)**

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |

Allergies: (please list medications only.) _____

Medications: (please list name, dose, and frequency)

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |

Family Medical History: (list medical illnesses affecting your immediate family)

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |

Social History: (please check all that apply)

single married widowed divorced/separated
tobacco use (packs per day): _____
alcohol use (drinks per week): _____

This document was reviewed by _____ M.D. Date _____