PERSONAL HISTORY QUESTIONAIRE

Please fill out and bring with you to the office on your initial visit

Name____ Date_______________________

Current area of complaint (**circle involved areas**):

A. Current Orthopedic Complaints:

neck pain	upper back pain	low back pain	right shoulder pain	left shoulder pain
right elbow pain	left elbow pain	right wrist/hand pain	left wrist/hand pain	right hip pain
left hip pain	right knee pain	left knee pain	right ankle/foot pain	left ankle/foot pain

B. Current Non-Orthopedic Complaints**:**

chest pain	abdominal pain	headaches

Current Treating Doctors:

Name:
Specialty:
Date started treatment:
Phone:
Condition Treated:
Name:
Specialty:
Date started treatment:
Phone:
Condition Treated:
Name:
Specialty:
Date started treatment:
Phone:
Condition Treated:
Name:
Specialty:
Date started treatment:
Phone:
Condition Treated:

Personal Medical History

Height:	Weight:
Smoker	The patient has smoked ______packs per day, month, for about ____years.
Coffee	The patient drinks about ______cups per day
Alcohol	The patient does have about _________ drinks per day, month, year.
Surgeries (year and body part):	
Major Illnesses:	
Broken bones(year and body part):	
Diabetes:	
Stroke:	
Cancer:	
Other:	
Car Accidents (year and body part injured):	

Family Medical History

Cardiac Problems:
Hypertension:
Diabetes:
Cancer:
Other:

Current Medications:

Medication name	Dosage	When Started

Testing and Exams

Last x-rays taken (year and body part):
Last MRI Performed (year and body part):
Last physical examination performed (year):

Signature________________________________ Date________________________________