Health History Questionnaire

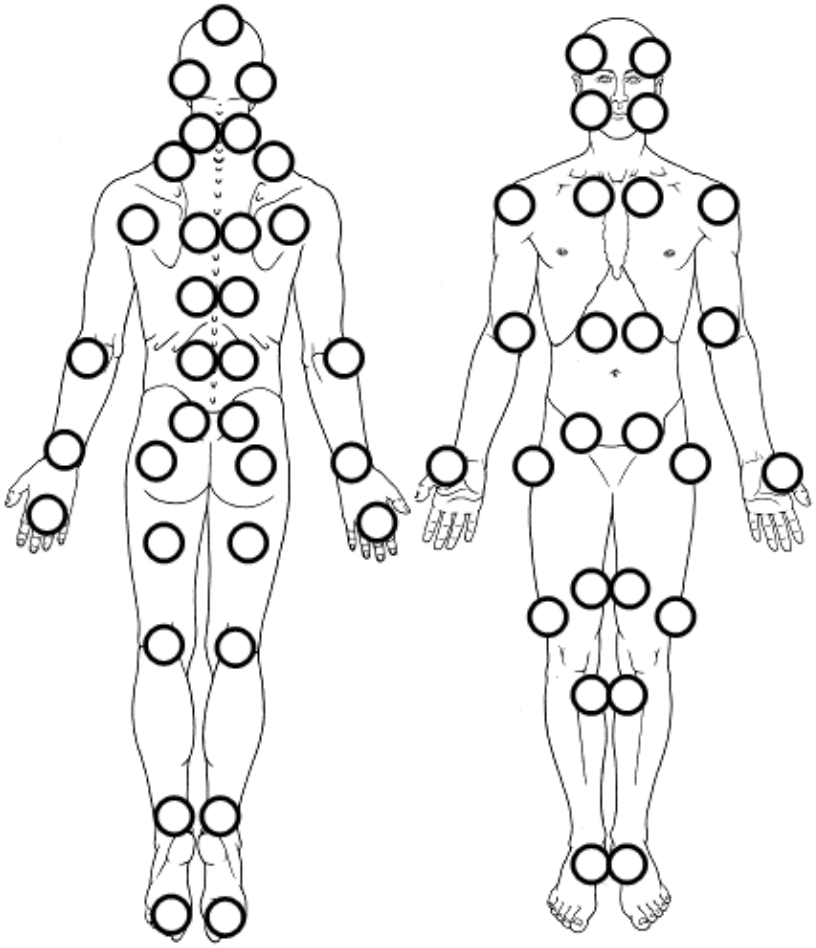
Name: _____
Date of Birth: _____ Today's Date: _____

Goals (Reasons) for Visit: (General)
_____
_____
_____

Please list the injuries you have had such as falls, blows to head or auto accidents that you recall in your lifetime.
_____
_____
_____
_____

Pain Severity

Think back over the past **2 WEEKS** for the **WORST** pain you have had. Please put **NUMBERS** in the circles that indicate how bad that pain was. 0 = No pain. 10 = The worst pain imaginable.



When did you first notice any pain or functional difficulty?
_____

How did your pain spread?
_____
_____
_____

What makes your pain worse?
_____
_____
_____

What type of practitioners have you seen for your pain? Circle

General Orthopedic Neurology Neurosurgery Chiropractor

What studies (IE X-ray, MRI, electrical tests, or Lab Work) have you received to evaluate your pain?

(Please bring in the written report with you if at all possible or try to find out who would have that)

Study Date What you were told.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

What diagnoses do you remember receiving for your pain?

_____

_____

What type of treatments have you received for your pain?

Medications: (Circle) Neurontin/gabapentin, Savella Cymbalta Amitriptyline Cyclobenzaprine/Flexeril Baclofen Ultram/tramadol Hydrocodone/Lortab Oxycodone/Percocet/Oxycontin Morphine

Non Medication Treatments: (Circle) Physical Therapy Massage Therapy Active Release Therapy TENS Acupuncture Manipulation Trigger Injection Epidural Steroids Radiofrequency Rhizotomies.

How is your Function Affected by Pain?

ACTIVITY	**Unaffected or Not Applicable**	**Pain but Not Limited**	**Pain Limited**	**Can't Do**
Bending				
Carrying				
Chores				
Computer Work				
Concentrating				
Dancing				
Gardening				

Lifting				
Jumping				
Pushing				
Reading				
Rolling Over				
Running				
Shoveling				
Sexual Activity				
Sitting				
Sleeping				
Standing				
Walking				
Working				

What are your evaluation and treatment goals? _____
_____
_____

Information About Other Medical Conditions You Have Had
(This is not about your family) (Circle or write-in if present)

- Alcoholism
- anemia/bleeding disorder
- arthritis (usual type)
- atrial fibrillation
- benign prostate swelling
- blood pressure elevation
- cancer history
- cardiomyopathy/weak heart
- cholesterol elevation
- chronic lung conditions
- chronic kidney damage
- chronic liver disease or hepatitis
- congestive heart failure
- coronary artery disease
- depression or psychiatric admission
- diabetes
- frequent urinary tract infection
- gout
- heart attack
- hypothyroidism
- neuropathy
- obesity
- peripheral vascular disease
- reflux
- seizures
- stroke
- ulcers in stomach
- _____
- _____
- _____

Review of Other Symptoms (Related or unrelated to your pain)
(Circle or write-in)

- appetite change
- blurry vision/glaucoma
- chest pain
- chronic anxiety
- chronic back pain
- chronic cough
- chronic headache
- clot in vein
- constipation or loose stools
- cool feet or pain in feet with walking
- dental problems
- hearing loss
- indigestion or nausea
- limited memory
- loud snoring or sleep apnea
- numbness or tingling
- rash or skin change
- restless legs
- shortness of breath
- sleep disorder
- urinary difficulty or leaking
- weight change
- _____
- _____
- _____

Surgeries Received
(Circle or write-in)

SURGICAL HISTORY:

- appendectomy
- carpal tunnel surgery
- cataract surgery
- cholecystectomy
- herniorrhaphy
- hysterectomy
- joint replacements
- tonsillectomy
- wisdom teeth extraction
- _____
- _____
- _____

Do you recall difficulty with sedation in the past by anesthesia or with pain meds such as being nauseated or “difficult to sedate”? Yes or No. If yes, please describe.

_____

_____

Lab Work Received

Have you had any blood test results that were abnormal as far as you can recall? Yes or No. If so, what? _____

Have you had a set of standard tests for arthritis? Yes No Don’t Know

Have you been tested for a thyroid disorder? Yes No Don’t Know

Have you been tested for iron overload? Yes No Don’t Know

Have you been tested for a vitamin D deficiency? Yes No Don’t Know

Medications, Allergies, and Supplements

Current Medications Taken Routinely

Name	Dosage	Name	Dosage
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Medications taken on an as needed basis

Name	Dosage	Name	Dosage
_____		_____	
_____		_____	

Supplements you have taken or are taking (Names only)

_____	_____
_____	_____
_____	_____
_____	_____

Drug Reactions, Allergies or Sensitivities (Latex and nuts included)

Name Reaction

_____
_____
_____
_____
_____

Family Health History

Have any of your relatives had the following? Place appropriate letter in box.

F = Father M = Mother S = Sister B = Brother A = Aunt U = Uncle GP = Grandparent

- Alcoholism _____
- anemia/bleeding disorder _____
- arthritis (usual type) _____
- atrial fibrillation _____
- benign prostate swelling _____
- blood pressure elevation _____
- cancer history _____
- cardiomyopathy/weak heart _____
- cholesterol elevation _____
- chronic lung conditions _____
- chronic kidney damage _____
- congestive heart failure _____
- coronary artery disease _____
- depression or psychiatric admission _____
- diabetes _____
- frequent urinary tract infection _____
- gout _____
- heart attack _____
- hypothyroidism _____
- neuropathy _____
- obesity _____
- peripheral vascular disease _____
- reflux _____
- seizures _____
- stroke _____
- _____
- _____
- _____

Social History

Are you: (Circle)
Married With Significant Other Single Divorced (year ____) Widowed (year ____)

What is your education? _____

What is your present job? _____

What is your spouse or significant other's occupation? _____

Do you have children? _____

How many total people (including yourself) live in your home? _____

Do you exercise? _____

What are the major stressors in your life? _____

What do you do to relieve stress? _____

Do you have a spiritual or religious practice? _____

What brings you joy? _____

What is most important to you? _____

If you need to have a driver for sedation, is someone available for that? _____

If you need someone to stay with you after sedation , is someone available for that? _____

TOBACCO/ALCOHOL/DRUG USE:
Have you ever smoked? Yes or No If yes how many packs per day for how many years _____
How many alcoholic drinks a day or week do you have?
_____ per day _____ per week or _____rare or _____ never
If you have other drug history, let us know privately at the time of your visit in the event it may be important.

BE SURE TO BRING THIS WITH YOU to your first visit.

Thank you,

Dr Reeves
Wpmed\web site files\patient intake and education files\health history questionnaire