

Patient Questionnaire

Patient Name _____ DOB: _____ AGE _____

Chief Complaint _____ Date of Injury: _____

Who referred you? Friend Relative Insurance website ER doctor: _____

Primary Care Physician's name: _____

Family Medical History (Please check if you or any blood relative has/had any of the following):

	You	Relative		You	Relative
1. Diabetes	_____	_____	16. Anemia	_____	_____
2. High/Low BP	_____	_____	17. Alcoholism	_____	_____
3. Hepatitis/Liver	_____	_____	18. Mental Illness	_____	_____
4. Heart Disease	_____	_____	19. Depression	_____	_____
5. Pulmonary Disease	_____	_____	20. HIV+	_____	_____
6. Kidney/Bladder	_____	_____	21. AIDS	_____	_____
7. Arthritis	_____	_____	22. Blood Transfusion	_____	_____
8. Osteoporosis	_____	_____	23. Hearing Disorder	_____	_____
9. Heart Attack	_____	_____	24. Eye Disease	_____	_____
10. Stroke	_____	_____	25. Epilepsy/Convulsions	_____	_____
11. High Cholesterol	_____	_____	26. Weight Loss/Gain	_____	_____
12. Stomach Ulcer	_____	_____	27. Migraine Headaches	_____	_____
13. Bowel Problems	_____	_____	28. Sinus/Throat	_____	_____
14. Neurological	_____	_____	29. Angina/Chest Pains	_____	_____
15. Cancer (Type) _____	_____	_____	30. Any Other Disease (If yes, give details) _____	_____	_____

Height _____

Weight (approximate) _____

ARE YOUR IMMUNIZATIONS CURRENT? Yes No

WHAT MEDICATIONS ARE YOUR CURRENTLY TAKING?
(Include prescription, non-prescription, Vitamins and Herbal preparations)

MEDICATION	DOSE	TIMES/DAY	MEDICATION	DOSE	TIMES/DAY
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

DRUG ALLERGIES

Drug	Reaction
_____	_____
_____	_____
_____	_____

DO YOU NOW OR HAVE YOU EVER USED:

Cigarettes? Y N _____ Pk/Day
 Alcohol? Y N _____ Glasses/Week
 Illegal Substances? Y N
 WOMEN: ARE YOU PREGNANT?
 YES NO

SURGERY: Have you ever had surgery? Yes No (Please give details)

SIGNATURE _____ **DATE** _____

(Parent/Guardian's signature if patient is a minor)