AUTO ACCIDENT ____YES ____NO
WORK ____YES ____NO
OTHER ____YES ____NO
INJURY DATE:____________________________
INJURY LOCATION:________________________
WHO REFERRED YOU ______________________

For Office Use Only
☐ New
☐ Change MRN:___________
☐ Copy of card attached

Medical History Questionnaire

Name ____ Age ______________
Date of Birth ______________________________Height ____________________ Weight ______________
Chief Complaint ____
Date of onset/injury____
How did this injury occur? ____
____
Occupation ____
List any allergies to medications, food, or skin allergies (tape, sutures, betadine, latex) ____________________
List reaction: ____
____

DO YOU HAVE A LUNG CONDITION? YES____ NO____ If yes, please explain ____________________________
____

DO YOU HAVE A HEART CONDITION? YES____ NO____ If yes, please explain ___________________________
____

Do you take Coumadin? YES____ NO____ How much and why? ____________________________________

Please circle if you have any of the following conditions and list specific type (if applicable):

Anemia-Type:____________________
Aneurysms
Angina
Artery Conditions
Asthma
Atrial Fibrillation (A-Fib)
Bladder Disease
Blood Disorder
Cancer-Type: ____________________
Treatment: ____ Chemo
____ Radiation
____ Surgery
In Remission Yes___ No___
Cardiac Stents

Chronic Leg Ulcers
Deep Vein Thrombosis
Diabetes-Type I (IDDM)
Diabetes-Type 2 (NIDDM)
Elevated Cholesterol
Emphysema
Gerd
Gout
Heart Attacks
Hepatitis-Type:____________________
High Blood Pressure
Hypothyroidism
Immune Deficiency
Kidney Disease
Lung Disease

Lyme Disease
Osteoarthritis
Osteoporosis
Peripheral Artery Disease (PAD)
Peripheral Vascular Disease (PVD)
Phlebitis
Pulmonary Embolism
Rheumatoid Arthritis
Scoliosis
Seizure Disorders
Sleep Apnea
Stomach Problems-Type ________________
Stroke__________________________
TB ____________________________

Any other conditions not mentioned above? ____
____

Family Medical History - List any pertinent family medical history:_____________________________
____
____
____

Do you smoke cigarettes? YES____ NO____ How long have you smoked and how much? ________________
Do you have a past history of smoking? If so, when did you quit?_______________________________
Do you drink alcohol? YES____ NO____ How long have you drank and how much? What type of alcohol?
____

Do you or have you used illicit drugs? YES____ NO____ If yes, please explain _______________________
____