

HEALTH QUESTIONNAIRE

DATE:

LAST NAME

FIRST NAME

DOB

ALLERGIES

No KNOWN DRUG ALLERGY

DYE

No Yes

LATEX ALLERGY No Yes

SHELLFISH

No Yes

MEDICATIONS

NONE

Include those you buy without prescription like Aspirin / NSAIDS

- | | | |
|--|--|--|
| <input type="checkbox"/> PERCOCET (ACETAMINOPHEN AND OXYCODONE) | <input type="checkbox"/> IBUPROFEN | <input type="checkbox"/> BLOOD PRESSURE MEDICINE |
| <input type="checkbox"/> VICODIN (ACETAMINOPHEN AND HYDROCODONE) | <input type="checkbox"/> ASPIRIN | <input type="checkbox"/> DIABETES MEDICINE |
| <input type="checkbox"/> OXYCODONE | <input type="checkbox"/> NAPROSYN / ALEVE (NAPROXEN) | <input type="checkbox"/> ASHAMA / COPD MEDICINE |
| <input type="checkbox"/> TYLENOL WITH CODEINE #3 | <input type="checkbox"/> LYRICA | <input type="checkbox"/> HEART MEDICINE |
| <input type="checkbox"/> FENTANY PATCH | <input type="checkbox"/> NEURONTIN (GABAPENTIN) | <input type="checkbox"/> ANTIBIOTICS |
| <input type="checkbox"/> MORPHINE | <input type="checkbox"/> CYMBALTA (DULOXETINE) | <input type="checkbox"/> MEDICINE FOR DEPRESSION |
| <input type="checkbox"/> TRAMADOL | <input type="checkbox"/> PLAVIX | |
| <input type="checkbox"/> FLEXERIL (CYCLOBENZAPRINE) | <input type="checkbox"/> COUMADIN (WARFARIN) | |

PAST MEDICAL HISTORY

NONE / NOT SIGNIFICANT

CHECK ALL THAT APPLIES

- | | | |
|---|--|--|
| <input type="checkbox"/> Low blood count (anemia) | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> DIABETES |
| <input type="checkbox"/> EASY BLEEDING | <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Heart Failure | |
| <input type="checkbox"/> Headaches / migraine | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Myofascial Pain |
| <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> TMJ pain | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> cramping of legs (walking or at rest) |
| <input type="checkbox"/> head injury | <input type="checkbox"/> Swelling of ankle | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> loss of appetite | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Glaucoma: R / L | <input type="checkbox"/> weight loss | <input type="checkbox"/> Fracture |
| <input type="checkbox"/> ringing in ears | <input type="checkbox"/> Nausea / vomiting | |
| <input type="checkbox"/> hoarseness | <input type="checkbox"/> REFLUX / ACIDITY / ULCER | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> bleeding gums | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> difficulty swallow | <input type="checkbox"/> colitis | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Sortness of breathing | <input type="checkbox"/> Chron's disease | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> difficulty initiating urination | <input type="checkbox"/> Depression |
| <input type="checkbox"/> TBC | <input type="checkbox"/> bladder incontinence | <input type="checkbox"/> Anxiety |
| | <input type="checkbox"/> Male: Prostate Problems | <input type="checkbox"/> Schizophrenia |
| | <input type="checkbox"/> Female: LMP _____ | <input type="checkbox"/> Suicidal ideation |
| | <input type="checkbox"/> Menopause | |

HOSPITALIZATIONS / SURGERIES

NONE / NOT SIGNIFICANT

- | | | |
|---|--|--|
| <input type="checkbox"/> LOWER BACK / SPINE SURGERY | <input type="checkbox"/> KNEE | <input type="checkbox"/> ABDOMINAL SURGERY |
| <input type="checkbox"/> NECK / SPINE SURGERY | <input type="checkbox"/> HIP | <input type="checkbox"/> CESAREAN SECTION |
| <input type="checkbox"/> THORACIC SPINE SURGERY | <input type="checkbox"/> SHOULDER | <input type="checkbox"/> HYSTERECTOMY |
| <input type="checkbox"/> OPEN HEART SURGERY | <input type="checkbox"/> ELBOW | <input type="checkbox"/> HERNIA REPAIR |
| <input type="checkbox"/> THORACOTOMY | <input type="checkbox"/> CARPAL TUNNEL | <input type="checkbox"/> FRACTURE REPAIR |

SOCIAL HISTORY

- USE OF ALCOHOL
- USE OF TOBACCO
- USE OF ILLICIT DRUGS
- NONE

Marital status:

- Single
- Married
- Divorced
- Widowed

CURRENT EMPLOYMENT STATUS:

- Employed
- Unemployed
- Retired
- On Disability

FAMILY HISTORY

IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF FOLLOWING -PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE

NONE / NOT KNOWN

- DIABETES
- ASTHMA
- HEART DISEASE
- HIGH BLOOD PRESSURE
- HIGH CHOLESTEROL
- CANCER

PAIN RELATED FAMILY HISTORY:

- | | | |
|----------------------|-------------------------|--------------------|
| 1) chronic neck pain | 6) multiple sclerosis | 11) alcoholism |
| 2) chronic back pain | 7) fibromyalgia | 12) drug abuse |
| 3) migraine | 8) rheumatoid arthritis | 13) depression |
| 4) chronic headache | 9) epilepsy | 14) panic disorder |
| 5) lupus | 10) suicide | 15) schizophrenia |