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PATIENT HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date: _____ Physician: _____

Injury or condition: _____

Please answer the following questions

- 1. On a scale of 0 – 10, with 10 being the most severe, circle the number that best describes your pain.
0 1 2 3 4 5 6 7 8 9 10
- 2. When did you first notice the pain?
____ days ago ____ weeks ago ____ months ago
- 3. Does anything make the problem worse?
____ Walking ____ Standing ____ Sitting
Other: _____
- 4. How long does your problem last?
____ 30 min. ____ 1 hour ____ constant
- 5. Please check what describes the problem best: ____ Dull
____ Shooting ____ Very sharp
____ Burning ____ Numbness
- 6. Does the problem interfere with your Normal activities? Yes No
Explain: _____

PAST MEDICAL HISTORY

Check all that apply

- | | |
|----------------------------|-------------------------------|
| _____ Diabetes | _____ History of Cancer |
| _____ High Blood Pressure | _____ Osteoporosis |
| _____ High Cholesterol | _____ History of Blood Clots |
| _____ Known Heart Disease | _____ Stroke |
| _____ Heart Attack | _____ Sciatica |
| _____ Asthma | _____ Other Neurological Cond |
| _____ Bronchitis/Emphysema | _____ Hepatitis |
| _____ History of Ulcers | _____ HIV/AIDS |
| _____ Hyper/Hypo Thyroid | Other Medical Illness: _____ |
| _____ Rheumatoid Arthritis | _____ |

PAST SURGICAL HISTORY

- | | | |
|--------------------|-------------------------------|---------------|
| _____ Appendix | _____ Breast Surgery | Others: _____ |
| _____ Gall Bladder | _____ Tonsillectomy | _____ |
| _____ Hysterectomy | _____ Spine Surgery | _____ |
| _____ Heart Bypass | _____ Total Joint Replacement | |
| _____ Pacemaker | _____ Arthroscopy | |

MEDICATIONS AND MEDICAL TESTS

Have you had _____ X-rays? _____ MRI?
Please list any allergies: _____
Please list medications you are taking: _____

SOCIAL HISTORY

Dominate Hand: Right Left What is your occupation? _____

Are you presently working? Yes No

List hobbies and recreational activities:

Do you live alone? Yes No

Do you have family or friends who live close to you? Yes No

Do you need assistance with your activities of daily living?

Dressing Grooming Driving

Lifting Overhead Reaching

Other _____

Are you under stress? Yes No

Sometimes I feel depressed:

Not at all Sometimes Often

Are you currently seeing a Psych/Social Services consultant?

Yes No

I would like to discuss my situation with a professional Psych/Social Services Provider.

Yes No

Signed: _____

Date: _____

Reviewed By: _____

Date: _____
