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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: \_\_\_\_\_

\_\_\_\_\_