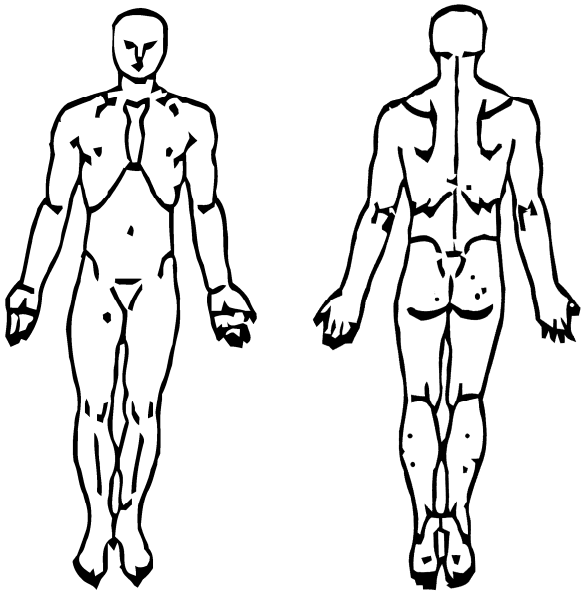
MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ TODAY'S DATE: _____

AGE: _____ WEIGHT: _____ HEIGHT: _____ OCCUPATION: _____

Please draw pain pattern on body chart below:



1. Where are your symptoms? _____

_____

2. When did it start? _____
3. Is your condition a result of an injury? If yes, describe briefly.

_____

4. Is your pain: Getting better / About the same / Getting worse
5. Rank your symptoms from 1-10. (1 being none, and 10 being unbearable):

   Average pain level in the last 48 hours: _____

   Lowest level of pain in the last 48 hours: _____

   Highest level of pain in the last 48 hours _____

6. What activities make your pain worse? lying down / standing / walking / sitting / stress
7. Any other activities that make your pain worse? _____
8. What can you do to relieve your pain? _____
9. Does your condition affect your sleep? Yes or No. If yes, can you go back to sleep? _____
10. Since this problem started what tests have been done? X-ray / MRI / CT Scan / EMG
11. Have you had any lab work done? Yes or No
12. Have you had anything similar to this condition? _____
13. List all medications which you are taking: _____

_____

14. Do you exercise? If yes, please describe: _____
15. Is there anything else that you would like to add? _____

_____

_____

MEDICAL HISTORY QUESTIONNAIRE (continued)

Past surgical history (date and type): _____

_____

Have you had a history of, or do you have the following:

____ Cancer	____ Kidney Disease	____ Diabetes	____ High Blood Pressure
____ Liver Disease	____ Stroke	____ Heart Disease	____ Angina/Chest pain
____ Fibromyalgia	____ Osteoporosis	____ Ulcers	____ Osteoarthritis
____ Allergies/Asthma	____ Rheumatoid Arthritis	____ Lung Disease	

Have you recently experienced abnormal sensations (eg, numbness, pins and needles)?	Y	N
Have you recently experienced headaches?	Y	N
Have you recently experienced night pain?	Y	N
Have you recently experienced sustained morning stiffness?	Y	N
Have you recently experienced light-headedness?	Y	N
Have you recently experienced trauma (eg, a motor vehicle accident, a fall)?	Y	N
Have you recently experienced night sweats?	Y	N
Have you recently experienced constipation?	Y	N
Have you recently experienced easy bruising?	Y	N
Have you recently experienced changes in vision?	Y	N
Have you recently experienced changes in menstruation patterns?	Y	N
Have you recently experienced gait or balance disturbances?	Y	N
Have you recently experienced chest pain with rest?	Y	N
Have you recently experienced shortness of breath?	Y	N
Have you recently experienced muscle weakness?	Y	N
Have you recently experienced a failure of conservative intervention (failure to improve within 30 days)?	Y	N
Have you recently experienced excessive sweating?	Y	N
Have you recently experienced edema or weight gain?	Y	N
Have you recently experienced a heartbeat in your abdomen when you lie down?	Y	N

MEDICAL HISTORY QUESTIONNAIRE (continued)

Have you recently experienced cramps in your legs when you walk for several blocks? Y N

Have you recently experienced abdominal pain? Y N

Have you recently experienced changes in the integrity of your nails? Y N

Have you recently experienced prolonged use of corticosteroids? Y N

During the past month, have you often been bothered by feeling down, depressed or hopeless? Y N

During the past month, have you often been bothered by little interest or pleasure in doing things? Y N

If you answered yes to one or both of the two previous questions, would you like help? Y N Yes, but not today. ____