Health History Questionnaire

Please shade or circle area(s) where symptoms occur:

Please rate your current degree of pain (0 – no pain, 10 – most severe pain):

0 1 2 3 4 5 6 7 8 9 10
No pain Most severe pain

Please rate your pain at its worst?

0 1 2 3 4 5 6 7 8 9 10
No pain Most severe pain

During which activity (ies) is your pain at its worst?

__________________________________________________

What makes your pain better?

____________________________________________

How did this injury occur?

____________________________________________________________________________________

When did the injury occur? __________________________________________________________________

Was this a re-injury?  □ No  □ Yes

When was the original injury? __________________________________________________________________

Was this injury evaluated by another physician?  □ No  □ Yes

Who? ____________________________________________  When? ________________________________________

Where? ______________________________________

Were you previously treated in physical therapy for this condition?  □ No  □ Yes  If yes, was it helpful?  □ No  □ Yes

Please indicate what studies were performed: □ X-ray  □ MRI  □ CT Scan  □ Ultrasound  □ Other (specify):

Results (if known): ______________________________________

Please list any prior surgery(ies):

____________________________________________________________________________________

Please list all current medications (Rx, Over the counter, Home remedy):

____________________________________________________________________________________

____________________________________________________________________________________

Do you have any medication allergy(ies)?  □ No  □ Yes  If yes, Please list:

____________________________________________________________________________________

Do you have any allergy(ies) to:  Iodine  □ No  □ Yes  Shellfish  □ No  □ Yes  Latex  □ No  □ Yes

Do you have any other allergy(ies)?  □ No  □ Yes  If yes, Please list:

____________________________________________________________________________________
MEDICAL HISTORY
Have you had a recent physical exam? □ No □ Yes
If yes, When? ________________________________
By Whom? ___________________________ For What? ________________________________

FAMILY HISTORY
Has any member of your family had a reaction to anesthesia? □ No □ Yes
If yes, what type of reaction? ______________________________________________________
What type of anesthesia? __________________________________________________________
Any family history of Bone Disease? □ No □ Yes
Any other family illness? □ No □ Yes If yes, explain: ________________________________________

SOCIAL HISTORY
Do you smoke? □ N □ Y (If yes, ____ pack(s) per day for ____ years). Have you quit within the past year? □ N □ Y
Do you drink alcohol? □ N □ Y If yes, number of drinks per week ______
Are you married? □ N □ Y Do you live alone? □ N □ Y Do you have family living locally? □ N □ Y

REVIEW OF SYSTEMS
To the best of your knowledge, do you now have or have you ever had any of the following:

Respiratory: No Yes
Asthma or Wheezing □ □
Shortness of breath at rest □ □
Chronic cough □ □

Ear/Nose/Throat: □ □
Lack of sense of smell □ □
Hearing loss □ □

Eyes: □ □
Double vision □ □
Vision problems □ □

Hematological/Lymph: □ □
Anemia □ □
Swollen glands □ □
Immune disease □ □
AIDS □ □
Blood clots □ □
Pulmonary Emboli □ □

Musculoskeletal: □ □
Curvature of the spine □ □
Arthritis/Joint pain □ □
Difficulty walking □ □

Skin: □ □
Bruise easily □ □
Psoriasis □ □
Eczema □ □

Neurologic: □ □
Stroke □ □
Head injury □ □
Numbness of arm/leg □ □

Endocrine: □ □
Diabetes □ □
Thyroid disorder □ □

Cancer: □ □
Type: __________________________
________________________________________
________________________________________

Cardiac: □ □
High Blood Pressure □ □
Heart Attack □ □
Irregular Heart Rate □ □
Pacemaker □ □
Rheumatic Fever □ □

Gl Tract: □ □
Liver disease □ □
Stomach ulcer □ □
Chronic heartburn □ □
Hiatal hernia □ □

Psychological: □ □
Depression □ □
Drug/Alcohol dependency □ □
Psychiatric treatment □ □

Constitutional: □ □
Unexplained Chills □ □
Unexplained Fever □ □
Significant Weight Gain □ □
Significant Weight Loss □ □

Communicable Diseases: □ □
Hepatitis □ □

Any Medical history not covered in any of the previous questions: _____________________________________________

How did you hear about MedSport? □ Advertisement □ Radio □ Website □ Family/Friend □ Physician
____________________________________________________________________________________________

Signature of Patient or Legally Authorized Representative (if patient is a minor or unable to sign) ________________________________

Date ______/_____/____ (mm/dd/yy)