East Suburban Sports Medicine Center MEDICAL HISTORY QUESTIONNAIRE

NAME:		DOB: _	AGE: t	EVAL DATE: _	
WEIGHT: H	HEIGHT:	GENDER: M	F MARITAL STATUS: 9	3	/ □ Other
REFERRING PHYSICIA	ΔN·				
MAIN PROBLEM AND	WHEN PAIN/SYN	IPTOMS:			
OTHER TREATMENT (PT, CHIROPRAC	TIC, ETC):			
DATE OF LAST PHYSI	CAL:	ALLE	RGIES:		
TESTS (X-RAYS, MRI,	BONE SCAN): _				
LIST OF MEDICATION	S :				
SURGERIES:					
EMERGENCY CONTAC	CT: (name)				
			(cell #)		
		MEDICAL SCF			
Have you or any immedi	T.		/e:	<u>Self</u>	<u>Family</u>
Cancer	<u>Self</u> Yes No Yes No	Yes No	Diabetes	Yes No	Yes No
High Blood Pressure	Yes No	Yes No	Heart Disease	Yes No	Yes No
Angina/Chest pain	Yes No		Stroke	Yes No	Yes No
Osteoporosis	Yes No	Yes No	Tuberculosis		Yes No
Arthritis	Yes No	Yes No	Thyroid condition	Yes No	Yes No
Do you have a history of	•				
Allergies	Yes No		Asthma	Yes No	
Kidney Disease	Yes No		Rheumatic fever		
Seizures	Yes No		Hepatitis	Yes No	
Bronchitis	Yes No		Ulcers	Yes No	
In the past 3 months have		ou experience:			
A change in your health			Night Pain	Yes	
Chest pain	Yes No		Numbness in genital/		
Changes in blodder function			Pregnancy	Yes	
Changes in bladder function			Vision Problems		
Dizziness/Fainting Fever/chills	Yes No Yes No		Hearing Problems Speech Problems	Yes Yes	
Headaches	Yes No		Shortness of Breath	Yes	
Nausea/Vomiting	Yes No		Unexplained Weakne		
Night Sweats	Yes No		Unexplained Weight		
Numbness/tingling	Yes No		Changes in appetite	Yes	No
Difficulty swallowing	Yes No		Upper respiratory infe		
Urinary tract infection	Yes No				
Are you currently:					
Depressed	Yes No				
Under stress	Yes No				
Have a pacemaker	Yes No				

How are you sleeping at night? (check one) Fine Moderate difficulty Only with medication												
Do you or	have :	you sr	noked	tobacc	o (circle	one) I	No Yes;	# pack	s/day	# of	years	Last tobacco use
Are your s	ympto	oms: (check (one) G	etting w	orse	Т	he same	e	Gettin	g better	
THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE:												
SIGNATURE								DA	_ DATE:			
Visual Pair	ı Scal	e:										
Please rate the severity of your pain by <u>circling</u> a number below:												
NO PAIN	0	1	2	3	4	5	6	7	8	9	10	UNBEARABLE PAIN
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PLEASE INDICATE THE PAINFUL AREAS OF YOUR CURRENT SYMPTO

Instructions:

- Circle each area of your pain or symptoms onto the chart below.
- Choose the number and letter from the lists below to describe your symptoms.
- Put the date each area of symptoms started for this episode to the best of your knowledge.

Please note the words that may help (Use all words that apply)

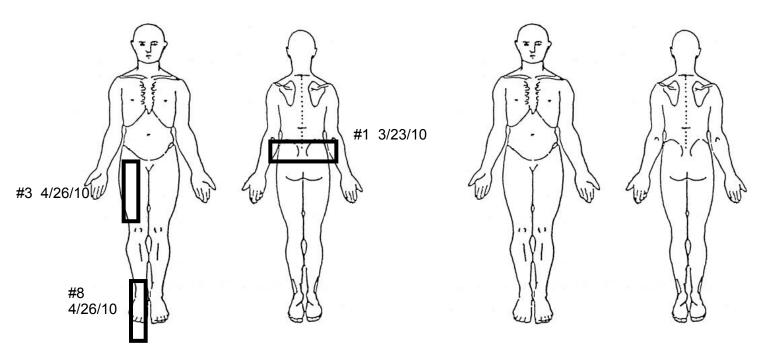
1 - sharp 7 - ache
2 - shooting 8 - tingling
3 - burning 9 - numb
4 - dull 10 - heavy
5 - throbbing 11 - tight
6 - pulling 12 - stabbing

Please note the words that describe your pain may help describe the symptoms:

- A. Constant (never goes away)
- B. Intermittent (relieved with position change or rest)
- C. Occasionally (daily or less frequent)
- D. Infrequent (once a week)
- E. Variable (comes and goes)

Example:

Please mark the areas of your symptoms:



Office documents / no ltrhd / Medical history questionnaire 12/2017