East Suburban Sports Medicine Center
MEDICAL HISTORY QUESTIONNAIRE

NAME: ____________________ **DOB**: __________ **AGE**: ______ **EVAL DATE**: __________

WEIGHT: __________ **HEIGHT**: __________ **GENDER**: M F **MARITAL STATUS**: ▫ S ▫ M ▫ D ▫ W ▫ Other

REFERRING PHYSICIAN: ____________________ **FAMILY PHYSICIAN**: ____________________

MAIN PROBLEM AND WHEN PAIN/SYMPTOMS: ____________________

____

OTHER TREATMENT (PT, CHIROPRACTIC, ETC): ____________________

DATE OF LAST PHYSICAL: ____________________ **ALLERGIES**: ____________________

TESTS (X-RAYS, MRI, BONE SCAN): ____________________

LIST OF MEDICATIONS: ____________________

SURGERIES: ____________________

EMERGENCY CONTACT: (name)____________________

(home phone #)____________________**(cell #)**____________________

MEDICAL SCREENING

Have you or any immediate family member been told you have:

	Self		Family			Self		Family	
Cancer	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	Yes	No	Stroke	Yes	No	Yes	No
Osteoporosis	Yes	No	Yes	No	Tuberculosis	Yes	No	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	Yes	No
Seizures	Yes	No	Hepatitis	Yes	No
Bronchitis	Yes	No	Ulcers	Yes	No

In the past 3 months have you had or do you experience:

A change in your health	Yes	No	Night Pain	Yes	No
Chest pain	Yes	No	Numbness in genital/anal area	Yes	No
Changes in bowel function	Yes	No	Pregnancy	Yes	No
Changes in bladder function	Yes	No	Vision Problems	Yes	No
Dizziness/Fainting	Yes	No	Hearing Problems	Yes	No
Fever/chills	Yes	No	Speech Problems	Yes	No
Headaches	Yes	No	Shortness of Breath	Yes	No
Nausea/Vomiting	Yes	No	Unexplained Weakness	Yes	No
Night Sweats	Yes	No	Unexplained Weight Change	Yes	No
Numbness/tingling	Yes	No	Changes in appetite	Yes	No
Difficulty swallowing	Yes	No	Upper respiratory infection	Yes	No
Urinary tract infection	Yes	No			

Are you currently:

Depressed	Yes	No
Under stress	Yes	No
Have a pacemaker	Yes	No

– OVER –

How are you sleeping at night? (check one) Fine ____ Moderate difficulty _____ Only with medication _____

Do you or have you smoked tobacco (circle one) No Yes; # packs/day ____ # of years ____ Last tobacco use ____

Are your symptoms: (check one) Getting worse _____ The same _____ Getting better _____

THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE:

SIGNATURE ____ DATE: ___________________

Visual Pain Scale:

Please rate the severity of your pain by circling a number below:

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 UNBEARABLE PAIN

PLEASE INDICATE THE PAINFUL AREAS OF YOUR CURRENT SYMPTOMS:

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
2 – shooting
3 – burning
4 – dull
5 – throbbing
6 – pulling
7 – ache
8 – tingling
9 – numb
10 – heavy
11 – tight
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: