Patient Questionnaire

Name: ____ **Date:** _________________________________

Please describe the problem you are here for today: [] Left [] Right [] Foot [] Ankle (Please explain below)

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How long have you had the problem? _______________________Date of Injury:____________________________________

If it is an injury where did it occur? [] Home [] School [] Auto [] Other____

How did the injury happen? ____

____

Please describe the type of pain you have: (check all that apply)

[] Sharp [] Aching [] Stabbing [] Dull [] Cramping [] Throbbing [] Pins and Needles [] Constant [] Comes and Goes

On a scale of 1-10, how severe is the pain? No Pain 1 2 3 4 5 6 7 8 9 10 Severe Pain

What is the location of your pain? ____

How long have you had this pain? ____

What makes it worse? ____

What makes it better? ____

Do you walk with an assistive device? [] Cane [] Crutches [] Walker

Who is your primary care physician? ____

What other specialists have you seen for this problem?____

Did you bring: [] X-Rays [] MRI [] CT [] Bone Scan

Medical History: Please check any problems that apply to you:

[] Childhood diseases
[] Mental Health Issues
[] HIV/AIDS
[] Other Infections
[] Pneumonia
[] Blood clots/phlebitis
[] Skin Changes
[] Mitral valve prolapse
[] Difficulty swallowing
[] Recent Head Trauma
[] High Risk Sexual Activity

[] Cancer
[] High blood pressure
[] Heart problems
[] Irregular heartbeat
[] Asthma/emphysema
[] Urinary infections
[] Alcoholism
[] Varicose veins
[] Hearing loss
[] Tatoos

[] Ulcers
[] Gallbladder problems
[] Colitis
[] Kidney problems
[] Thyroid problems
[] Psoriasis
[] Drug Abuse
[] Weight change
[] Visual disturbances
[] Hepatitis
[] Difficulty Urinating

[] Bleeding problems
[] Hiatal hernia
[] Tuberculosis
[] Arthritis
[] Diabetes
[] Gout
[] Stroke
[] Seizures
[] Sinus problems
[] Liver Problems

[] Neuromuscular disorders (Parkinson's Disease, Multiple Sclerosis, etc.)

[] No medical problems

Please describe any of the problems you have check off from the above list: ____________________________________

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Name: ____ **Date:** __________________________________

Surgical History:

Please list any surgeries you have had in the past? ____

Have you ever had general anesthesia? [] Yes [] No If yes, any Problems? [] Yes [] No

Current Medications: Please list prescription and over the counter medications

Name of Medication:	Dosage (example 10 mg.)	How often do you take it:
_______________________	_______________________	_____________________
_______________________	_______________________	_____________________
_______________________	_______________________	_____________________
_______________________	_______________________	_____________________

Allergies: Please include the reaction you had: ____

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Family Medical History: Please check any of the following medical problems anyone of your immediate family (Mother, Father, Sister, Brother, Grandparents) has had:

[] Arthritis	[] Heart Problems	[] Cancer	[] Kidney Problems
[] Diabetes	[] Asthma/emphysema	[] Bleeding Problems	[] HIV/AIDS
[] Drug abuse	[] Psychiatric problems	[] High Blood Pressure	[] Alcoholism
[] Stroke	[] Anesthesia problems	[] Tuberculosis	[] Hepatitis

Social History:

[] Employed [] Student [] Disabled [] Retired

Occupation________________________ Employer ___________________________ Number of Years ___________________

Do you get regular exercise? [] Yes [] No If yes, what type of exercise and how often?____________________________

Do you drink alcohol? [] Yes [] No If yes, how many drinks per week? ______________________________

Do you smoke? [] Yes [] No If yes, how many per day? ________ How long have you smoked? _______________

Height_____ Weight_____ Shoe Size_____

Do you have any of the following: [] Dentures [] Glasses or contact lenses [] Hearing Aid

For inter-office use:
Dates Updated

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