PATIENT HISTORY QUESTIONNAIRE

Your answers on this form will help your provider understand your medical concerns and conditions better. This form will be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. **Thank you!**

TODAY'S DATE _____

NAME _____ AGE_____ DOB _____

REASON FOR TODAY'S VISIT: _____

Approximate date symptoms started: _____

ARE YOU ALLERGIC TO ANY MEDICINES? ☐ YES ☐ NO If yes, please list: _____

_____

IS VISIT RELATED TO WORK OR AUTO INJURY? ☐ YES ☐ NO Date of injury _____

PLEASE LIST ALL PAST OPERATIONS AND SERIOUS ILLNESSES:

Operation or Illness	Month and Year	City, State

Recent x-rays, labs or tests	Date	Facility/Doctor

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

Medicine	Dose	Frequency	For What Illness?

DO YOU CURRENTLY TAKE: HERBAL SUPPLEMENTS, SUCH AS GINGKOBA OR ST. JOHNS WORT OR ASPIRIN PRODUCTS? ☐ YES ☐ NO

If yes, please list _____

SOCIAL HISTORY:

Do you smoke? ☐ YES ☐ NO If yes, how much? _____

Do you drink alcohol? ☐ YES ☐ NO If yes, how much? _____

Previous steroid use? ☐ YES ☐ NO If yes, how much? _____

FAMILY HISTORY:	Age	Diseases/Conditions	If Deceased, Cause of Death
FATHER			
MOTHER			
SIBLINGS			
SPOUSE			
CHILDREN			