Scottsdale Joint Center

Health History Questionnaire

Today's Date_____

Patient's name_____ DOB: _____

Referring and Primary Care Doctors Names_____

Reason for today's visit_____

_____

Was your problem a result of a work injury or other accident? ____ Yes_____ No?

Date of Injury _____If yes, Please explain_____

Are legal proceedings now pending this evaluation? ____Yes ____ No?

Any special request: _____

Medical History: Current and past medical problems: Check all that apply. ***Give year if appropriate***

Heart Disease	Heart Attack	Heart Failure	Arrhythmia
High Blood Pressure	Stroke	Lung Disease	Asthma
Diabetes	Stomach ulcer	Colon Cancer	GI Bleeding
Hepatitis	Hiatal Hernia	Appendicitis	Gall Bladder Disease
Pancreatitis	Liver disease	Kidney Disease	Chest Pains
Dental Disease	Phlebitis	DVT (vein Clot)	Pulmonary Embolism
Neurological Disorder	Urinary Disorder	HIV + /AIDS	ANEMIA
Thyroid imbalance	High Cholesterol	Valley Fever	Cancer (type)

Please list any other health problems_____

_____

_____

_____

What allergies to medication do you have? _____

_____

_____

What medications do you presently take?

1.	2.	3.
4.	5.	6.
7.	8.	9.
10.	11.	12.

What is your current: Height_____ Weight_____?

What operations (all types) have you previously had and year? _____

_____

_____

_____

Family History:

Is there a family history of any disorders? _____

_____

_____

Social History/Habits:

Do you smoke? YES/NO –About how many cigarettes a day? _____

Do you drink more than one alcoholic beverage a day? _____

Do you have a prior history of drug abuse? _____

Do you have a prior history of alcohol abuse? _____

Special Situations:

If this involves a serious accident (automobile, fall, bike, skates, etc…) Please describe the circumstances:

_____

_____

_____

If an auto accident, was your seatbelt on? YES/NO- Were you the driver?_____ or a passenger?_____

Rate your PRESENT pain level from 1 to 10 (10 being worse):_____

What makes the pain better? _____

What makes the pain worse? _____

Check all that apply to pain onset: sudden _____gradual _____ lifting _____bending _____sports_____

_____unknown onset _____auto accident _____hurt at work

If you have back pain; does it radiate down your - Right leg? _____ Left Leg? _____ Both Legs? ____

Which pain is worse, the back or leg pain? _____

Have you had previous back/spine surgery? When? _____

What diagnostic Orthopedic Tests have you had beside X-rays? _____

CAT/CTT Scans date_____ Results known? _____

MRI Scans date _____Results known? _____

Bone Scans date _____ Results known?_____

What other doctors have you seen for this same condition?_____

Have you had Physical Therapy for this pain? When?_____ How Long?_____