Patient Questionnaire

Name: ____ Date: ___________________

Allergies to Medications: ____

Latex Allergy?: Yes____ No____ Allergy to Tape?: Yes____ No ____

Current Medications: ____

Height: _______ Weight: _______ Resp. Rate: _______

Medical History *(please circle yes or no):*

Y/N Liver (hepatitis, cirrhosis)
Y/N Kidney (stone, failure)
Y/N Lung (asthma, COPD)
Y/N Heart (murmur, MI, bypass/stent)
Y/N High Blood Pressure
Y/N Stomach (ulcer, reflux)
Y/N Diabetes
Y/N Thyroid

Y / N Arthritis
Y / N Neurologic (seizure, stroke)
Y / N Bleeding Problems
Y / N Cancer: ____________________
Y / N Skin problems
Y / N Circulation
Y / N Depression/Anxiety
Y / N Substance Abuse (drugs, alcohol)
Y / N Other ______________________

Are you/could you be pregnant: Yes ____ No____

Do you smoke: Yes____ No ____ How much?:____________________________________

Have you had surgery in the past? If so please list:____

____

Review of Symptoms

A. General:
- ☐ Fevers, chills or sweat
- ☐ Recent unexpected weight loss

B. Eyes:
- ☐ Blurred or double vision
- ☐ Loss of Vision

C. Ears, Nose, Throat
- ☐ Earache
- ☐ Decreased hearing
- ☐ Difficulty swallowing
- ☐ Sinus trouble or congestion

D. Cardiovascular:
- ☐ Chest pain
- ☐ Palpitation (fast, irregular heart)
- ☐ Shortness of breath with exertion

E. Respiratory:
- ☐ Chronic cough
- ☐ Chronic shortness of breath

F. Gastrointestinal:
- ☐ Persistent nausea/vomiting
- ☐Diarrhea
- ☐ Constipation
- ☐ Chronic abdominal pain

G. Musculoskeletal:
- ☐Jointpain
- ☐ Muscle weakness
- ☐Arthritis

H. Skin:
- ☐ Skin rashes

I. Neurologic:
- ☐ Headache
- ☐ Weakness

J. Psychological:
- ☐ Feeling depressed, sad
- ☐ Memory loss

K. Endocrine:
- ☐ Cold or heat intolerance
- ☐ Excessive thirst and urination

L. Blood/Lymphatic:
- ☐ Excessive bruising or bleeding

M. Allergic/Immunologic:
- ☐ Sneezing
- ☐ Coughing
- ☐ **OTHER**:_______________

Patient Signature	Date	Initial if No Change	Patient Signature	Date	Initial if No Change

Patient Questionnaire

This Column For Doctor's Use Only

Name: ____

Date: ____

Age: ________________ Are you (right or left) handed: _________________________

Occupation: ____

Are you currently working: Yes____ No____ If not, since when: _______________

If not, why?: ____

Primary Care/ Referring Physician: ____

Address: ____

____

What is your hand/arm problem?: ____

____

____

When and How did the problem begin: ____

____

Any special testing: ____

Any treatment? Please describe: ____

____

What makes you feel better: ____

What makes you feel worse: ____

Prior hand problems: ____