

### Patient Questionnaire

Full Name \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

Referred by \_\_\_\_\_ Primary Care Provider \_\_\_\_\_

What brings you here today? \_\_\_\_\_  
 \_\_\_\_\_

Which side is affected? \_\_\_\_\_ Which hand do you write with? \_\_\_\_\_

Date of injury/problem onset \_\_\_\_\_ **Do you have a Worker's Compensation claim for this issue?**

Occupation \_\_\_\_\_ Hobbies (sports, musical instruments, etc.) \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

**Medical History**

		yes	no			yes	no
High Blood Pressure				Peptic Ulcer Disease (stomach ulcers)			
Heart Problems/MI				Bleeding Problems			
Breathing/Respiratory Problems				Problems taking Ibuprofen/NSAIDS/Aspirin			
Kidney disease				Taken steroid medication			
Hepatitis/Liver disease				Alcohol/Drug addiction			
Diabetes				Arthritis			
Thyroid problems				Recent Infections			
Stroke / CVA				Are you possibly pregnant?			
Cancer				Are you a current tobacco user?			
Autoimmune disease (Rheumatoid, Lupus, etc)				Any other medical problems?			

Please explain any yes answers:

\_\_\_\_\_  
 \_\_\_\_\_

Have you ever had surgery? \_\_\_\_\_ If yes, please list:

\_\_\_\_\_  
 \_\_\_\_\_

What medicines do you take currently or have taken in the past 3 months:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**May we download your Medication History from the Pharmacy Database?**

Which pharmacy do you use? \_\_\_\_\_ Address: \_\_\_\_\_

Do you have any allergies to medicine or biologics? \_\_\_\_\_ If so, please list **AND** include reaction

\_\_\_\_\_  
 \_\_\_\_\_

Any major medical problems run in the family? \_\_\_\_\_ (Please specify relationship)

\_\_\_\_\_  
 \_\_\_\_\_

Are you currently experiencing any of the following:

	yes	no
Unexpected weight loss or weight gain, fever, fatigue		
Corrective lenses, blurred/double vision, eye pain, redness, watering		
Headache, difficulty swallowing, nose bleeds, ringing in ears, earache		
Chest pain, palpitations, fainting, murmurs		
Shortness of breath, wheezing, chest tightness, cough		
Heartburn, nausea, vomiting, constipation, diarrhea		
Frequency, urgency, and/or painful/bloody urination, side or low back pain		
Joint pain, swelling, instability, stiffness, redness, muscle pain		
Skin changes, slow/poor healing, rash, itching, redness		
Numbness/tingling, unsteady gait, dizziness, tremors, seizure		
Nervousness, anxiety, depression		
Easy bleeding, bruising		
Excessive thirst or urination, heat/cold intolerable		

Please explain any yes answers:

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