

# HEALTH QUESTION

PATIENT NAME: \_\_\_\_\_ TODAYS Date: \_\_\_\_\_

REASON FOR VISIT: \_\_\_\_\_

LIST ANY MAJOR INJURIES YOU HAVE SUFFERED AND APPROXIMATE DATE, INCLUDING FRACTURES: \_\_\_\_\_

DO YOU HAVE ANY MEDICAL PROBLEMS I SHOULD BE AWARE OF?  
\_\_\_\_\_

HAVE YOU EVER HAD AN ALLERGIC REACTION TO ANY MEDICINE? \_\_\_\_\_ PLEASE LIST: \_\_\_\_\_

HAVE YOU EVER BEEN HOSPITALIZED FOR ANY REASON OTHER THAN SURGERY OR CHILBIRTH? PLEASE LIST: \_\_\_\_\_

YEAR	ILLNESS	HOSPITAL (city and state)
_____ //	_____ //	_____ //
_____ //	_____ //	_____ //

PLEASE CHECK ANY ILLNESS YOU MAY HAVE HAD:

\_\_\_ ALCOHOLISM      \_\_\_ DRUG ABUSE      \_\_\_ SUICIDE ATTEMPT  
\_\_\_ DEPRESSION      \_\_\_ ANXIETY      \_\_\_ NERVOUS BREAKDOWN

## HEALTH HABITS

DO YOU CURRENTLY SMOKE CIGARETTES? \_\_\_\_\_ If yes, How many packs a day \_\_\_\_\_

HOW LONG HAVE YOU SMOKED? \_\_\_\_\_ IF YOU ARE A FORMER SMOKER,

WHEN DID YOU STOP? \_\_\_\_\_ HOW LONG DID YOU SMOKE? \_\_\_\_\_

HOW MANY PACKS PER DAY? \_\_\_\_\_

DO YOU DRINK ALCOHOL? \_\_\_\_\_

PLEASE LIST ANY PHYSICIANS, CHIROPRACTORS, PHYSICAL THERAPISTS, ETC. YOU HAVE BEEN CONCERNING YOUR ARTHRITIS COMPLAINTS:

NAME	ADDRESS	PHONE #
_____ //	_____ //	_____ //
_____ //	_____ //	_____ //

DO YOUR ARTHRITIC COMPLAINTS STEM FROM AN INJURY FROM WHICH A LAWSUIT IS CURRENTLY PENDING OR PLANNED? \_\_\_\_\_ YES \_\_\_\_\_ NO

IF YES, WHAT WAS THE DATE OF THE ACCIDENT? \_\_\_\_\_

PLEASE LIST NAME, PHONE NUMBER, AND ADDRESS OF THE LAWYER YOU ARE USING. \_\_\_\_\_

IS THERE A HISTORY OF ARTHRITIS IN YOUR FAMILY? PLEASE CHECK AND LIST THE INVOLVED MEMBERS:

GOUT \_\_\_\_\_ RHEUMATOID ARTHRITIS \_\_\_\_\_ LUPUS \_\_\_\_\_  
OSTEOARTHRITIS \_\_\_\_\_ OTHER \_\_\_\_\_

PLEASE PUT A "X" NEXT TO THE JOINT WHICH YOU HAVE OR HAD SYMPTOMS IN DIFFICULTY IN SWELLING, STIFFNESS, PAIN OR LOSS OF MOTION:

	HAVE/HAD		HAVE/HAD
HANDS	___ ___	KNEES	___ ___
WRISTS	___ ___	ANKLES	___ ___
ELBOWS	___ ___	FEET	___ ___
SHOULDER	___ ___	NECK	___ ___
HIPS	___ ___	BACK	___ ___

HAVE YOU EVER HAD BURSTITIS? \_\_\_ YES \_\_\_ NO  
 HAVE YOU EVER HAD TENDONITIS? \_\_\_ YES \_\_\_ NO

PLEASE MARK ANY TEST YOU HAVE EVER HAD IN A PREVIOUS EVALUATION OF YOUR ARTHRITIC CONDITION.

\_\_\_ X-RAY OF WHAT \_\_\_\_\_ WHEN \_\_\_\_\_  
 \_\_\_ CAT SCAN \_\_\_\_\_ MYELOGRAM \_\_\_\_\_  
 \_\_\_ ARTHRITIS LAB TEST RESULTS: \_\_\_\_\_

HAVE YOU HAD ANY SURGERY ON YOUR JOINTS, BACK, OR NECK?  
 PLEASE LIST \_\_\_\_\_

HAVE ANY OF THE FOLLOWING MODALITIES BEEN USED TO TREAT YOUR ARTHRITIC CONDITION?

	<u>WHEN</u>
___ PHYSICAL THERAPY	_____
___ OCCUPATIONAL THERAPY	_____
___ PAIN CLINIC	_____
___ TRACTION	_____
___ CHIROPRACTIC THERAPY	_____

PLEASE CHECK NEXT TO THE FOLLOWING MEDICATIONS YOU USE TO TREAT YOUR ARTHRITIC PROBLEM

___ PREDNISONE	___ MECLOMEN	___ VOLTAREN	___ SOMA
___ PENICILLAMINE	___ NALFON	___ ROBAXIN	___ PERCOSET
___ VIOXX	___ FLEXERIL	___ DARVOCET	___ MOTRIN
___ COLCHICINE	___ TYLENOL3	___ GOLD	___ FELDENE
___ CELEBREX	___ INDOCIN	___ PLAQUENIL	___ AZULFIDINE
___ GLUCOSAMINE	___ NAPROSYN	___ ORUDIS	___ ELAVIL
___ CHONDROITIN	___ CLINORIL	___ DOLOBID	___ TYLOX
___ IMURAN	___ CITOXAN	___ ANSAID	___ TRILISATE DISALCID
___ TOLECTIN	___ ASPIRIN	___ METHOTREXATE	

PLEASE CHECK THE FOLLOWING SYMPTOMS YOU HAVE OR HAD THAT YOU FEEL ARE SIGNIFICANT:

___ HEADACHES	___ IRRITABLE BOWEL SYND	___ PERSISTANT COUGH
___ ABDOMINAL PAIN	___ HAIR LOSS	___ TROUBLE SWALLOWING
___ CONJUNCTIVITIS	___ DIARRHEA	___ FEVER
___ DRY EYES	___ DRY MOUTH	___ GASTOINTESTINAL BLEEDING
___ SHORTNESS OF BREATH	___ FATIGUE	___ MUSCLE WEAKNESS
___ HEAD PAIN	___ HEEL PAIN	___ NUMBNESS/TINGLING
___ COUGHING UO BLOOD	___ JAW PAIN	___ SCALP TENDERNESS
___ HEARTBURN	___ SKIN RASH	___ SKIN TIGHTENING
___ COLOR CHANGES OF FINGERS	___ MOUTH SORES	___ TROUBLE SLEEPING
___ GENITAL SORES	___ SHAKING OR CHILLS	___ SEIZURES
___ SKIN ULCERS	___ VOMITING/NAUSEA	___ DEPRESSION
___ KIDNEY FAILURE	___ PSORIASIS	
___ CARPAL TUNNEL SYND	___ PERICARDITID	
___ PLEURISY	___ CHEST PAIN	