HEALTH HISTORY QUESTIONNAIRE

Today's date ____/_____/_____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME: (Last, First, M.I.)	□ Male □ Female	DOB _____/_____/_____ SSN _____/_____/_____	AGE _____

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address _____City/State _____ Zip _____

Telephone ( ) _____ Cell Phone and/or pager_____

Patient/Parent Name & Employer _____Address_____

City/State _____ Zip _____ Telephone ( )_____

Occupation _____ Type of work _____
(i.e. Standing, Sitting, Bending, Lifting)

Current work status _____
(i.e. Full time, Part time, Out of work)

Date of injury/accident or onset of symptoms _____ Date of surgery_____

If you have received Home Health Care, please list the number of visits _____

If you have received Home Health Care, please circle the agency responsible for your care

CareSouth Gentiva Advanced Home Care Other _____

Please list any previous accidents, orthopaedic problems or previous surgeries

_____

Referring doctor: _____ **Date of Next Follow-up Appt.** _____

Exercise Health Habits: (Please circle the most appropriate)

Sedentary (No exercise) **Mild exercise** (i.e. climb stairs, walk 3 blocks, golf)

Occasional vigorous exercise (i.e. work or recreation 4x/per week for less than 30 minutes)

Regular vigorous exercise (i.e. work or recreation 4x/per week for 30 minutes or more)

PERSONAL HEALTH HISTORY

Do you have or have you had any of the following: ☐ High Blood Pressure ☐ Pacemaker ☐ Heart Condition ☐ Stroke ☐ Diabetes ☐ Cancer □ Other _____

Briefly List Your Current Medications:

Name the Drug:	**What is the medication used for?**
_____	_____
_____	_____
_____	_____
_____	_____

Please list any allergies to medications:	**What was/is the reaction?**
_____	_____
_____	_____
_____	_____