Name:
DOB:
Gender:
Date:

MOTIONORTHOPAEDICS

HEALTH HISTORY QUESTIONNAIRE

Name: _____ **Date:** _____ Age: Sex: Ht: Wt:

Primary Physician: _____ Who referred you? ☐ Right ☐ Left Handed

What is(are) your i**njured body part(s) or condition(s)?** _____

When did it begin? _____

How did it occur? _____

What makes it **worse?** _____
(SITTING / STANDING / LYING FLAT / DOING NOTHING / BENDING / LIFTING / TWISTING / COUGHING / SNEEZING)

What makes it **better?** _____
(SITTING / STANDING / LYING FLAT / DOING NOTHING / WALKING / EXERCISE / HEAT / COLD)

Type in or Circle your **pain** levels: {Least Pain ---------- Most Pain}

Worst Level: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Best Level: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Today: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Since the start of the problem, are you: ☐ IMPROVING ☐ GETTING WORSE ☐ STAYING THE SAME

Who have you seen for this problem? _____

What **tests** have been done? When?

X-RAY: ☐ MRI: ☐ CT: ☐ NERVE STUDY (EMG): ☐ OTHER: _____

What **treatment(s)** have you had for this problem?

Medications: _____ Helped? ☐ Y ☐ N ☐ Not Sure

Physical Therapy: ☐ Y ☐ N When? _____ How many visits? _____ Helped? ☐ Y ☐ N ☐ Not Sure

Injections (type / date): _____ Helped? ☐ Y ☐ N ☐ Not Sure

Surgery (type / date): _____ Helped? ☐ Y ☐ N ☐ Not Sure

Restricted Job Duties: No lifting over: _____ Other: _____ _____

(RegularJob Duties): No Lifting over: _____ Other: _____

Have you ever had any problems with any of these body areas before? When? _____

Patient Signature: _____ Date: _____

☐ By Checking this box, I affirm my intent to sign this form electronically by typing my name above.

Name:
DOB:
Gender:
Date:

HEALTH HISTORY QUESTIONNAIRE

Past Medical History:

Stroke	☐	Asthma	☐	Cancer	☐	Phlebitis	☐	Other Illnesses	
Heart Trouble	☐	Acid Reflux	☐	Bleeding Disorders	☐	Anemia	☐		
High Blood Pressure	☐	Gout	☐	Alcoholism	☐	Stomach Ulcers	☐		
High Cholesterol	☐	Seizures	☐	Serious Injuries	☐	Liver Disease	☐		
Diabetes	☐	Mental Illness	☐	Lung Disease	☐	Thyroid Disease	☐		
Arthritis	☐	Kidney Disease	☐	Tuberculosis	☐	AIDS	☐		

Past Surgical Procedures: _____

_____

_____

Allergies to Medication(s) or Other: NONE or List: _____

☐ Latex ☐ Iodine ☐ Shellfish ☐ Adhesives ☐ Contrast Dye

Current Medication(s): _____ _____ _____
(Please list doses if available) _____ _____ _____
_____ _____ _____

Marital Status: MARRIED / SINGLE / DIVORCED / WIDOWED
Highest Education Level: ELEMENTARY SCHOOL / HIGH SCHOOL / COLLEGE / GRADUATE SCHOOL
Certificate / Degree? _____
Tobacco use? ☐ N ☐ Y ____ packs per day for ____ years. Year quit? ____ Recreational drug use? ☐ Y ☐ N
Alcohol use? ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ HEAVY Any history of drug / alcohol abuse? ☐ Y ☐ N
Regular Exercise Routine? ☐ Y ☐ N Describe: _____ Hobbies? _____
Current Job Title: _____ Employer: _____ How long? _____
Employment status: WORKING FULL DUTY / WORKING WITH RESTRICTIONS / OFF WORK / DISABLED / RETIRED

Family Medical History:

Stroke	☐	Diabetes	☐	Seizures	☐	Cancer	☐	Other Illnesses	
Heart Disease	☐	Arthritis	☐	Mental Illness	☐	Bleeding Disorders	☐		
High Blood Pressure	☐	Gout	☐	Kidney Disease	☐	Alcoholism	☐		

Review of Systems: (recent or current conditions)

☐ Weight Change	☐ Hearing Changes	☐ Shortness of Breath	☐ Urinary Burning	Women only:	
☐ Fever / Chills	☐ Ear Pain / Ringing	☐ Cough	☐ Frequent Headaches	☐ Irregular Periods	
☐ Night Sweats	☐ Nosebleeds	☐ Nausea / Vomiting	☐ Seizures	☐ Pregnant	
☐ Poor Appetite	☐ Hoarseness	☐ Stomach Pain	☐ Numbness	☐ Other Illnesses	
☐ Rash	☐ Difficulty Swallowing	☐ Frequent Diarrhea	☐ Weakness		
☐ Insomnia	☐ Tooth / Gum Disease	☐ Frequent Constipation	☐ Backache	_____	
☐ Depression	☐ Chest Pain	☐ Blood in Stool	☐ Joint Pain	_____	
☐ Anxiety	☐ Abnormal Heartbeat	☐ Incontinence	☐ Joint / Limb Swelling	_____	
☐ Visual Changes	☐ Blackouts	☐ Urinary Frequency	☐ Lumps / Masses	_____	

Patient Signature: _____ Date: _____

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