VISALIA MEDICAL CLINIC, INC. — MEDICAL QUESTIONNAIRE

Due to government requirements that physicians document complete medical information on each patient, we ask you to complete the following detailed form in its entirety. Should you have trouble with any of the questions, please feel free to ask our staff for assistance. Some of the information may be sensitive; rest assured that the staff will keep this information confidential. Thank you for your cooperation.

1. PATIENT IDENTIFICATION

Name:_____ Date:_____ Updated:_____

Age:_____ Date of Birth:_____ Who is your primary / family doctor?:_____

How were you referred to our office: ❑ Self ❑ ER (which one?):_____

❑ Referred By (name):_____ ❑ Other (list name):_____

2. PRESENTING COMPLAINT / PROBLEM

Reason for visit:_____ Date of onset:_____

Cause of injury:_____ Where occurred?:_____

Work-related?: ❑ Yes ❑ No Previous injury?:_____

Previous studies? Where performed & Date?

X-Rays_____ MRI_____

CT Scan_____ Bone Scan_____

Other_____ Nerve Conduction Studies_____

❑ Right Handed ❑ Left Handed

PAIN DRAWING

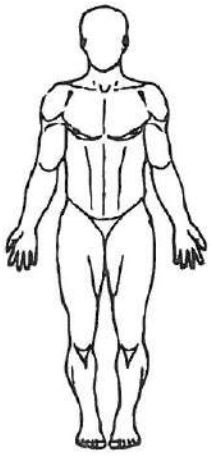
Be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

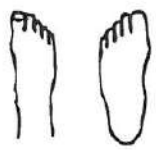
Numbness = = = = | Pins & Needles o o o o | Burning Pain x x x x | Stabbing Pain / / / / | Aching Pain ((((

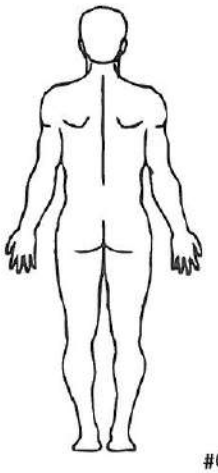
No Pain Severe Pain

0 1 2 3 4 5 6 7 8 9 10

PAIN SCALE







3. MEDICAL HISTORY

CHECK YES or **NO** to indicate if you have EVER had any of the following disorders, and **circle** the appropriate condition.

General: Rheumatoid Arthritis, Cancer (where)_____ ❑ Yes ❑ No

Eyes / Ears: Glaucoma, Hearing Loss ❑ Yes ❑ No

Neuro: Migraine headaches, Seizures, Epilepsy, Stroke, Polio, Nerve Injury, Meningitis ❑ Yes ❑ No

Endocrine: Diabetes, Thyroid Disorder, Adrenal Insufficiency ❑ Yes ❑ No

Cardiac: Coronary Artery Disease, Angina, Heart Attack, Arrhythmia, Valve Disease, Rheumatic Fever, Stents ❑ Yes ❑ No

Respiratory: Asthma, Emphysema, Tuberculosis, Blood clot to lungs, Bronchitis, Pneumonia ❑ Yes ❑ No

GI: Reflux / Ulcer Disease, Liver Disease / Hepatitis, Bowel Disease ❑ Yes ❑ No

GU: Kidney Disease, Renal Failure, Urinary Problems, Prostate Problems, Infections ❑ Yes ❑ No

Vascular: High blood pressure, Phlebitis, DVT / Clot, Anemia, Bleeding Disorder ❑ Yes ❑ No

Psych: Mental illness, Depression, Bipolar Disorder, Anxiety ❑ Yes ❑ No

Other: Alcoholism, Osteoarthritis, Osteoporosis, AIDS, Social Drugs, _____ ❑ Yes ❑ No

Serious Injury: (where?)_____ ❑ Yes ❑ No

4. PREVIOUS SURGERIES / HOSPITALIZATIONS – list all past surgeries and dates

Any complications with surgery or anesthesia?:

5. MEDICATIONS – INCLUDE HERBAL SUPPLEMENTS AND OVER THE COUNTER MEDICATIONS

MEDICATION	DOSE # TIMES PER DAY	MEDICATION	DOSE # TIMES PER DAY

6. ALLERGIES (DRUG REACTIONS)

Are you allergic to any drugs or have you had any reactions to medications? ❑ Yes ❑ No
If YES, **LIST** the drugs **and** the type of reaction:

7. FAMILY HISTORY (biological grandparents, parents, siblings) – is there a family history of any serious medical conditions – such as diabetes, hypertension, heart disease, cancer?

❑ Yes ❑ No if YES, please explain:_____

8. SOCIAL HISTORY

❑ Single ❑ Married ❑ Divorced ❑ Widowed Number of children living_____

Presently living alone? ❑ Yes ❑ No

Stairs at home? ❑ Yes ❑ No Number of steps_____

Occupation:_____Still at work? ❑ Yes ❑ No if no, last date worked:_____

How long at present job?_____

Physical demands of work: ❑ Heavy ❑ Moderate ❑ Light ❑ Lifting ❑ Pushing
❑ Squatting ❑ Prolonged standing ❑ Sitting

Alcohol use: ❑ Never ❑ Rare ❑ Occasional ❑ Moderate ❑ Heavy ❑ Quit how many years ago?_____

Tobacco use: ❑ Nonsmoker ❑ Smoker #packs per day_____Years_____
❑ Previous Smoker How many years ago?_____

Drug use: ❑ Yes ❑ No ❑ Past What type?_____

Sports / Exercise prior to injury? ❑ Yes ❑ No What type?_____

Number of times/week:_____ ❑ Recreational ❑ School / College level ❑ Semi / Professional

How has injury affected these activities?_____

9. REVIEW OF SYSTEMS General Health: ❑ Good ❑ Average ❑ Fair ❑ Poor

Circle **to indicate if you have had any of the following symptoms pertaining to today's visit only.**

Unexplained weight loss, Fatigue, Fever, Chills. Blurred vision

Hearing loss, Ringing in ears, Hoarseness, Sore throat

Chest pain, Palpitations, Irregular heart beat, Murmur, Racing heart, Lower ext. edema

Shortness of breath, Cough, Blood in sputum, Wheezing, Sleep apnea

Abdominal pain, Constipation, Diarrhea, Vomiting blood, Black stool, Nausea, Jaundice

Burning with urination, Urinary frequency, Blood in urine

Bone or joint infections, Swollen joint, Gout, metal implant, fractures or dislocations

Skin color changes, Rashes, Lesions, Nodule, Skin ulcers

Headache, Dizziness, Seizures, Difficulty walking, Tingling

Anxiety, Depression, Nervousness, Insomnia

Bruise easily, Swollen glands, Nosebleeds, Gum bleeding, Blood disorders

Prior blood transfusions? If yes, when _____

Are you claustrophobic? YES or NO Are you pregnant? YES or NO

Other symptoms? Please specify_____

Patient Signature_____ **Date**_____

I have reviewed this form and used the data in forming my opinion and making recommendations

Physician's Signature_____**Date**_____

Physician's Signature_____**Date**_____