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PHYSICAL – HEALTH HISTORY QUESTIONNAIRE

Patient Information: ➤**Please provide a photo ID to be scanned.**

Social Security #:	*Sex:*	*Employment Status:*
Full Name:	*DOB:*	*Employer:*
Address:	*Marital Status:*	*Address:*
	Race/Ethnicity:	
City/State/Zip:	*Language:*	*Home #:*
Email: ❒None		*Cell #:*
Primary Care Provider:		*Work #:*

Emergency Contact:

Name:	*Language:*	*Cell #:*
Sex: *DOB:*	*Home #:*	*Work #:*
Patient's relationship to Emergency Contact:		

Pharmacy:	*Mothers Maiden Name:*

Health History: Last Tetanus ____/____/____ ☐ Unknown Hepatitis B Titer ____/____/____ ☐ Unknown

Allergies: ☐ No Allergies ☐ Medication ☐ Food ☐ Environmental

Please specify: ____

____

Medications: List all medicines you are **CURRENTLY** taking.

Name of Medication	Dosage	Reason

Current Medical Conditions: Please check any **CURRENT** problems or symptoms you have on the list below:

Constitutional
- ☐ Fevers/chills/sweats
- ☐ Unexplained weight loss/gain
- ☐ Change in energy/weakness
- ☐ Frequent thirst or urination

Eyes
- ☐ Sensitivity to Light
- ☐ Change in Vision

Ears/Nose/Throat/Mouth
- ☐ Difficult hearing/ringing in ears
- ☐ Problems with teeth/gums
- ☐ Hay fever/allergies

Cardiovascular
- ☐ Chest pain/discomfort
- ☐ Irregular heart beat
- ☐ High Blood Pressure

Respiratory
- ☐ Cough/wheeze
- ☐ Difficulty breathing

Gastointestinal
- ☐ Abdominal Pain
- ☐ Blood in bowel movement
- ☐ Nausea/vomiting/diarrhea

Genitourinary
- ☐ Nighttime urination
- ☐ Leaking Urine

Musculo-skeletal
- ☐ Muscle/joint pain
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Muscle weakness

Blood/Lymphatic
- ☐ Easy bruising/bleeding
- ☐ Unexplained lumps
- ☐ Diabetes

Neurological
- ☐ Headaches
- ☐ Dizziness/light-headedness
- ☐ Numbness
- ☐ Memory Loss
- ☐ Loss of Coordination

Psychiatric
- ☐ Anxiety/stress
- ☐ Problems with sleep
- ☐ Depression

Other
- ☐ ______________________________

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Past Medical History: Have you **EVER** had… Check all that apply.

- ☐ Eye Problems/Foreign Body
- ☐ Color Blindness
- ☐ Ear or Hearing Problems
- ☐ Nutrition Problems
- ☐ Nose Problems
- ☐ Mouth/Oral Problems
- ☐ Lung Problems
- ☐ Lung Infection
- ☐ Asthma
- ☐ Emphysema
- ☐ Pacemaker/Stent
- ☐ Angina/Chest Pain
- ☐ Heart Disease
- ☐ Metal in any part of your body
- ☐ High Blood Pressure
- ☐ Liver Problems
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Stomach Problems
- ☐ Stomach Ulcers
- ☐ Colitis
- ☐ Urinary Problems
- ☐ Kidney/Bladder Infection
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Bleeding Problems
- ☐ Skin Problems
- ☐ **Normal Health, NONE OF THE ABOVE**
- ☐ Joint Replacement
- ☐ Arthritis
- ☐ Cancer
- ☐ Radiation/Chemo
- ☐ Carpal Tunnel
- ☐ Diabetes
- ☐ Gout
- ☐ Hay Fever
- ☐ Hives
- ☐ Neurological Problems
- ☐ Head/Spine Problems
- ☐ Prior Back Strains
- ☐ Ruptured Disc
- ☐ Migraines
- ☐ Seizures
- ☐ Sports Injuries
- ☐ Muscle Problems
- ☐ Sprains or Strains
- ☐ Any Prior Work Injury
- ☐ Chiropractic Care
- ☐ Tendonitis
- ☐ Depression
- ☐ Anxiety
- ☐ Substance Abuse
- ☐ Hernia
- ☐ Loss of Consciousness

Please explain: ______________________________

____

Serious Injuries, Illness, Hospital Stays Or Operations: List and give dates.

____

____

Family Medical History: Please describe medical history in your family (If deceased, list cause of death and age):

Mother ______________________________

Father ______________________________

Sisters ______________________________

Brothers ______________________________

Social & Work History:

For this job are you: Full Time Part Time Temporary Start Date: ______________

Type of Job/Position: ______________________________

Please list in order all jobs including military and farming. This information is used to determine the type of work you have done in the past.

Start	End	Employer	Job duties

Are you working elsewhere in addition to this job? ______________________________

What are your hobbies? ______________________________

Are you currently a smoker? ☐ Yes ☐ No

Circle if you have **EVER** smoked: Cigarettes Pipe Cigar Chewing Average packs/day: _________ How Many Years? ________

Vaped How long: ________________ How often: ______________

How often do you drink alcoholic beverages? (Circle one) Never Seldom Weekends

Type of alcoholic beverage normally consumed? (Circle one) Wine Beer Other ________ Amount per time ____________

Work Related Health History: Please check all that you have been exposed to during work or hobby activity.

- ☐ Ammonia
- ☐ Asbestos
- ☐ Beryllium
- ☐ Cadmium
- ☐ Coal dust
- ☐ Cold (severe)
- ☐ Excessive dust
- ☐ Fiberglass
- ☐ Heat (severe)
- ☐ Isocyanates/urethanes
- ☐ Ketones
- ☐ Lasers
- ☐ Lead
- ☐ Mercury
- ☐ Noise (loud)
- ☐ Pesticides
- ☐ Silica sand
- ☐ Solvents
- ☐ Spray painting
- ☐ Styrene
- ☐ Vibration
- ☐ Welding fumes
- ☐ X rays
- ☐ Other

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Have you developed or had any known health problems due to your present or past employment? (Include: injuries, illnesses, and possible allergies).

☐ No ☐ Yes, Explain: ____________________

Previously filed a workers compensation claim?

☐ No ☐ Yes, Explain: ____________________

Previously received an impairment rating or permanent work restriction?

☐ No ☐ Yes Explain: ____________________

Been off work for more than 3 days because of an illness or injury related to work?

☐ No ☐ Yes Explain: ____________________

Changed jobs or work assignments because of a health problem or injury?

☐ No ☐ Yes Explain: ____________________

Worked with a substance which caused you to break out in a rash?

☐ No ☐ Yes Explain: ____________________

Worked with a substance which caused trouble breathing? (cough, shortness of breath, wheezing, etc)

☐ No ☐ Yes Explain: ____________________

Been treated for psychiatric, alcohol or drug related illnesses?

☐ No ☐ Yes Explain: ____________________

Had any type of reaction when wearing latex gloves?

☐ No ☐ Yes Explain: ____________________

Do you experience pain/discomfort in your back or have you been under a doctor/chiropractor's care for back problems?

☐ No ☐ Yes Explain: ____________________

Do you experience pain or discomfort in your neck, shoulder, elbow, wrist or hand such as tendonitis, carpal tunnel syndrome or have you been under a doctor's care for such problems?

☐ No ☐ Yes Explain: ____________________

Do you have a hobby, craft or business that you do outside of this job?

☐ No ☐ Yes Explain: ____________________

Do you use any assistive devices such as prostheses, braces, artificial limbs, artificial eye, cane, or hearing aid?

☐ No ☐ Yes Explain: ____________________

Have any known physical or mental impairments, limitations, or disabilities?

☐ No ☐ Yes Explain: ____________________

Do you feel safe at home? ☐ No ☐ Yes

Do you know where to go for help if you were experiencing violence in your home? ☐ No ☐ Yes

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Attestation: I certify that the above answers are true and correct to the best of my knowledge. **Any deliberate falsification of a response may be grounds for dismissal by the employer.** **Initial:** ____________

Authorization To Release: I hereby authorize my physician and/or records acquired during the course of examination or treatment of the work-related injury/illness identified above to my employer, their insurance carrier, case manager or designated representative for the purpose of coverage determination and processing payment/insurance claims. **Initial:** ____________

Financial Policy: I hereby authorize payment for charges incurred for services rendered by «PracticeName», directly to the physician and/or «PracticeName». I realize any non-covered services will be my responsibility. **Initial:** ____________

Patient Signature: ______________________________ **Date:**

Provider Comment: ______________________________

______________________________ **Date:**

Provider Signature: ______________________________ **Time:** ____________