SMART
HEALTH & WELLNESS
STAY IN THE GAME

MEDICAL QUESTIONNAIRE

KINDLY USE BLACK INK

GENERAL

Name *Last Name* *First Name* *M.I.*				Today's Date (MM/DD/YYYY) / /
Gender ☐ Male ☐ Female	Height	Weight	Age	Which is your dominant hand? ☐ Left ☐ Right
Referring Doctor & Phone			Primary Care Doctor & Phone	

Have you been discharged from an inpatient facility in the past 30 days? If yes:

What was your date of discharge?

Were any of your medications changed?

CURRENT PROBLEM

What part of your body are you being seen for today? Which side? (if applicable) ☐ Left ☐ Right

What is the goal of your appointment today?

☐ Pain Management ☐ Better Function ☐ Better Appearance ☐ Return to Work ☐ Return to Play ☐ Other: _____

How did the problem develop?

When did the problem start: ☐ Over Time (Duration:_____) ☐ Injury (Date of Injury: _____)

Is this work related? ☐ Yes ☐ No

On a scale of 0-10 (0=no pain, 10= worst possible pain) what is your level of pain? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Do you have: ☐ Numbness? ☐ Tingling? If yes, where:

Have you noticed any weakenss? ☐ Yes ☐ No If yes, explain:

What other symptoms do you have?

Do your symptoms limit your ability to work? ☐ Yes ☐ No If yes, explain:

Do your symptoms affect your activities of daily living? ☐ Yes ☐ No If yes, explain:

Do your symptoms keep you awake at night? ☐ Yes ☐ No

What treatments have you tried? ☐ Injection ☐ Physical Therapy ☐ Chiropractic ☐ Medication:_____ ☐ Other: _____

Have any treatments helped? ☐ Yes ☐ No Please explain:

How many street blocks can you walk?

Do you use a walking device? ☐ Cane ☐ Crutches ☐ Walker ☐ Wheel Chair ☐ Not Applicable; Don't use a walking device

Describe how you use stairs: ☐ Place one foot per step ☐ Place both feet on step before proceeding to next ☐ Not Applicable; Don't use stairs

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MEDICAL HISTORY: LIST ALL

Medications:

Supplements:

Drug allergies (include reaction):

Medical problems:

Surgeries:

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed **Name:**

Hobbies / Interests: **Occupation:**

Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No

If "Yes": How often did you have a drink containing alcohol in the past year?

☐ Never (0 point) ☐ Monthly or less (1 point) ☐ 2 to 4 times a month (2 points)

☐ 2 to 3 times a week (3 points) ☐ 4 or more times a week (4 points)

Do you use tobacco products? ☐ No ☐ Yes **If yes, how many packs per day?**

Do you use recreational drugs? ☐ No ☐ Yes **Describe:**

IF YOU ARE 65 OR OLDER

Do you have an advance care plan or surrogate decision maker?

Have you fallen in the last 12 months? ☐ No ☐ Yes **If "Yes": How many times?** **Were you injured?**

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient / Representative Name (print) _____ **Signature**_____ **Date**____/____/____

USE BLACK INK

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HEALTH REVIEW (Do you have any of the following?)

GENERAL			***GASTROINTESTINAL***		
Have you been in good general health most of your life	☐ No	☐ Yes	Vomiting blood or food	☐ No	☐ Yes
Any allergies, including medication	☐ No	☐ Yes	Gallbladder disease	☐ No	☐ Yes
Any recent weight gain	☐ No	☐ Yes	Liver trouble	☐ No	☐ Yes
SKIN			Hepatitis	☐ No	☐ Yes
Skin Disease	☐ No	☐ Yes	Painful bowel movements	☐ No	☐ Yes
Jaundice	☐ No	☐ Yes	Black stools	☐ No	☐ Yes
Hives, eczema or rash	☐ No	☐ Yes	Hemorrhoids or piles	☐ No	☐ Yes
Frequent infections or boils	☐ No	☐ Yes	Recent changes in bowel habits	☐ No	☐ Yes
Abnormal pigmentation	☐ No	☐ Yes	Heartburn or indigestion	☐ No	☐ Yes
HEAD, EYES, EARS, NOSE, THROAT			***GENITOURINARY***		
Eye diseases or injury	☐ No	☐ Yes	Loss of urine	☐ No	☐ Yes
Wear glasses	☐ No	☐ Yes	Frequent urination	☐ No	☐ Yes
Double vision	☐ No	☐ Yes	Night time urinating	☐ No	☐ Yes
Headaches	☐ No	☐ Yes	Blood in urine	☐ No	☐ Yes
Glaucoma	☐ No	☐ Yes	Kidney trouble / Kidney stones	☐ No	☐ Yes
Itching eyes or nose	☐ No	☐ Yes	***LOCOMOTOR - MUSCULOSKELETAL***		
Sneezing or runny nose	☐ No	☐ Yes	Osteoporosis	☐ No	☐ Yes
Nosebleeds	☐ No	☐ Yes	Varicose veins	☐ No	☐ Yes
Chronic sinus trouble	☐ No	☐ Yes	Weakness of muscles or joints	☐ No	☐ Yes
Ear disease	☐ No	☐ Yes	Difficulty walking	☐ No	☐ Yes
Impaired hearing	☐ No	☐ Yes	Pain in calves or buttocks on walking, relieved by rest	☐ No	☐ Yes
Dizziness or transient episodes of unconsciousness	☐ No	☐ Yes	***NEURO - PSYCHIATRIC***		
RESPIRATORY			Ever had psychiatric care	☐ No	☐ Yes
URI (cold) now	☐ No	☐ Yes	Ever been advised to see a psychiatrist	☐ No	☐ Yes
Spitting up blood	☐ No	☐ Yes	Fainting spells	☐ No	☐ Yes
Chronic of frequent cough	☐ No	☐ Yes	Convulsions	☐ No	☐ Yes
Asthma or wheezing	☐ No	☐ Yes	Paralysis	☐ No	☐ Yes
Difficulty breathing	☐ No	☐ Yes	***ENDOCRINE***		
CARDIOVASCULAR			Diabetes	☐ No	☐ Yes
Chest pain or angina pectoris	☐ No	☐ Yes	Thyroid disease	☐ No	☐ Yes
Shortness of breath with walking or lying down	☐ No	☐ Yes	Hormone therapy	☐ No	☐ Yes
Heart trouble or heart attacks	☐ No	☐ Yes	Any change in hat or glove size	☐ No	☐ Yes
High blood pressure	☐ No	☐ Yes	Any change in hair growth	☐ No	☐ Yes
Swelling of hands, feet or ankles	☐ No	☐ Yes	Become colder than before or skin become dryer	☐ No	☐ Yes
Heart murmur	☐ No	☐ Yes	***HEMATOLOGICAL***		
NECK			Slow to heal after cuts	☐ No	☐ Yes
Stiffness	☐ No	☐ Yes	Blood disease	☐ No	☐ Yes
Enlarged glands	☐ No	☐ Yes	Anemia	☐ No	☐ Yes
			History of blood clots	☐ No	☐ Yes
			Bleeding problems	☐ No	☐ Yes

FAMILY'S HEALTH REVIEW (Has any blood relative ever had any of the following?)

Cancer	☐ No	☐ Yes	Convulsions	☐ No	☐ Yes
Tuberculosis	☐ No	☐ Yes	Suicide	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes	Mental illness	☐ No	☐ Yes
Heart trouble	☐ No	☐ Yes	Bleeding tendency	☐ No	☐ Yes
High blood pressure	☐ No	☐ Yes	Gout or other arthritis	☐ No	☐ Yes
Stroke	☐ No	☐ Yes	Hereditary defects	☐ No	☐ Yes

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient / Representative Name (print)_____ **Signature**_____ **Date**____/____/____