# VINCENT L. GUMBS, M.D.

**ORTHOPEDIC SURGERY**
**16542 Ventura Blvd., Ste. 122, Encino, CA 91436-2005**

## PATIENT QUESTIONNAIRE

Name _____ Date of Examination _____

Complete Address _____

DOB _____ Age ____ Soc. Sec. # _____ Telephone Number (  ) _____

Height ___ ft. ___ in. o Right-handed o Left-handed
Weight _____ lbs. SEX: o Female o Male

Date(s) of Injury _____ Time of Injury: _____

WORK HISTORY

Name of employer at time of injury(ies): _____
When did you start working for the company? _____
Date you last worked: _____

Job title: _____
Describe your duties: _____
_____
_____

What physical activities were required on your job? (For example: Sit, stand, walk, bend, reach, knee, climb, crawl, crouch, bend, ascend or descend stairs or ladders, push, pull, lift, carry, etc.)
_____
_____
_____

How much were you required to lift and/or carry as part of your job duties? _____

How much can you lift and/or carry at this time? _____

How much could you lift and/or carry before your present injury? _____

Hours worked per day _____ per week _____ What were your hours? _____ a.m. to _____ p.m.

## CURRENT WORK STATUS

Are you still employed by the company? o yes o no
Are you currently working for them? o yes o no If Yes: o regular job duties o light job duties

What are your light job duty restrictions? _____

If you are not currently working, when did you last work for company (date)? _____

Are you disabled? o yes o no
Are you currently receiving disability benefits as a result of the work injury? o yes o no
If yes, from whom? o Workers' compensation insurance carrier
o State Disability Insurance fund

Present Employer & Job Title: _____

## OCCUPATIONAL HISTORY

Who did you work for before working for this employer? _____
How long did you work there? _____
What was your job title? _____
What were your job duties? _____
Did you have any injuries on that job? o yes o no
If yes, what is the date of the injury? _____
What were your injuries? _____
Was there a settlement? o yes o no If yes, how much was the settlement? _____

## HISTORY OF INJURY

In your own words, please describe the injury and include…What were you doing? How did it occur? What part(s) of your body was hurt? (Use other side if necessary)

_____
_____
_____
_____
_____

Did you report the injury? _____ If so, to whom? _____ When? _____

Describe your medical treatment:
(Where, when, by whom, what type. Where were you seen first? What treatment did you receive? Were you referred elsewhere?)

_____
_____
_____
_____

Were you returned to work? _____ If yes: o modified **or** o regular job duties.
If you returned to work with restrictions, what were your restrictions? _____
_____
Were you later taken off work? _____ If so, when and by whom? _____

Were x-rays or other special studies done? o yes o no If Yes: which body part(s): _____
_____

| SPECIAL STUDIES | Body Part | Date Performed | Location Performed | Result |
|---|---|---|---|---|
| EMG, NCV | | | | |
| CT Scan | | | | |
| MRI | | | | |
| Bone Scan | | | | |
| Myelogram | | | | |
| Arthrogram | | | | |
| Other | | | | |

Did you receive physical therapy? o yes o no If yes, for how long? _____
How often? _____

Did this treatment help? o yes o no

Did you have surgery? o yes o no
If yes, when? _____

Are you still receiving treatment? o yes o no
If yes, what type? _____

Describe any further medical and/or chiropractic treatment you have received to this date, as a result of the injury(ies): _____
_____
_____
_____

Please list the names and dates from the first doctor you saw to the present:

| Name | Specialty | City | Referred By | Exam Date |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

With the treatment provided to date, do you feel your condition is:
o Fully recovered o Improved o No change o Worse
Explain: _____
_____
_____

Have you missed any time from work because of the injury? o yes o no
If yes, what was your first day of lost time? _____
If yes, when did you return to work? _____
Were you ever told to return to modified work? o yes o no
What were your restrictions _____
If yes, did you return to work? o yes o no When? _____
Is modified work available? o yes o no
When do you expect to return to your regular work? _____

CURRENT MEDICAL TREATMENT

Are you still seeing a doctor at this time? o yes o no If yes, date last seen: _____
Next appointment _____ Doctor's name ___ _____ MD, DC
How often? o Weekly o Monthly o As Needed o Other _____

Are you taking any medications? o yes o no
If yes, name of medications: _____
How often do you take them? _____
Does the medication help you? _____

Are you currently receiving physical therapy? o yes o no
Is physical therapy helping? _____

PRESENT COMPLAINTS
(per body part)

## Please: ONLY COMPLETE the body parts that were injured.

NECK

Are you still having pain? o yes o no If so, which part? _____

Describe the pain: [Constant (100%), frequent (75%), intermittent (66%), occasional (33%)] _____

How does the pain feel? (Sharp, dull, aching, stabbing, burning, etc.) _____

What makes the pain worse? _____

What decreases the pain? _____

Using the pain scale below, how would you describe your pain? Please circle the number that best estimates the amount of pain:

Before the injury: no pain ←----------→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Your pain now: no pain ←----------→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Does your present pain travel to other parts of the body? o yes o no
If yes, where? _____

Do you experience stiffness? o yes o no

Do you experience weakness? o yes o no

Do you experience numbness? o yes o no

Do you experience tingling? o yes o no If so, where? _____

Do you have swelling? o yes o no

Any popping of the joints? o yes o no

Any locking of the joints? o yes o no

Any giving way of joints? o yes o no

Is there increased pain with coughing or sneezing? o yes o no

SHOULDERS

Are you still having pain? o yes o no If so, which shoulder? _____

Describe the pain: [Constant (100%), frequent (75%), intermittent (66%), occasional (33%)] _____

How does the pain feel? (Sharp, dull, aching, stabbing, burning, etc.) _____

What makes the pain worse? _____

What decreases the pain? _____

Using the pain scale below, how would you describe your pain? Please circle the number that best estimates the amount of pain you are currently experiencing.

Before the injury: no pain ←----------→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Your pain now: no pain ←----------→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Does your present pain travel to other parts of the body? o yes o no
If yes, where? _____

Do you experience stiffness? o yes o no Do you experience weakness? o yes o no

Do you experience numbness? o yes o no Do you experience tingling? o yes o no

Do you have swelling? o yes o no

Any popping of the joints? o yes o no

Any locking of the joints? o yes o no

Any giving way of joints? o yes o no

Have you had prior surgery? o yes o no If so, when? _____

Do you have pain raising your hand above shoulder level? o yes o no

Have you had a shoulder dislocation? o yes o no

ELBOWS

Are you still having pain? o yes o no If so, which elbow? _____

Describe the pain: [Constant (100%), frequent (75%), intermittent (66%), occasional (33%)] _____

How does the pain feel? (Sharp, dull, aching, stabbing, burning, etc.) _____

What makes the pain worse? _____

What decreases the pain? _____

Using the pain scale below, how would you describe your pain? Please circle the number that best estimates the amount of pain you are currently experiencing.

Before the injury: no pain ←----------→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Your pain now: no pain ←----------→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Does your present pain travel to other parts of the body? o yes o no
If yes, where? _____

Do you experience stiffness? o yes o no

Do you experience weakness? o yes o no

Do you have swelling? o yes o no

Do you experience numbness? o yes o no

Do you experience tingling? o yes o no If so, where? _____

Any popping of the joints? o yes o no

Any locking of the joints? o yes o no

Any giving way of joints? o yes o no

Have you had prior injury? o yes o no If so, when? _____

Have you had any surgery on you elbow? o yes o no If so, when? _____

WRIST/HAND

Are you still having pain? o yes o no If so, which wrist/hand? _____

Describe the pain: [Constant (100%), frequent (75%), intermittent (66%), occasional (33%)] _____

How does the pain feel? (Sharp, dull, aching, stabbing, burning, etc.) _____

What makes the pain worse? _____

What decreases the pain? _____

Using the pain scale below, how would you describe your pain? Please circle the number that best estimates the amount of pain you are currently experiencing.

Before the injury: no pain ←----------→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Your pain now: no pain ←----------→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Does your present pain travel to other parts of the body? o yes o no
If yes, where? _____

Do you experience stiffness? o yes o no

Do you experience weakness? o yes o no

Do you experience numbness? o yes o no

Do you experience numbness in fingers? o yes o no If so, which fingers? _____

Do you experience tingling? o yes o no If so, where? _____

Do you have swelling? o yes o no

Any popping of the joints? o yes o no

Any locking of the joints? o yes o no

Any giving way of joints? o yes o no

Did you have any surgeries? o yes o no If so, when? _____

HIPS

Are you still having pain? o yes o no If so, which hip? _____

Describe the pain: [Constant (100%), frequent (75%), intermittent (66%), occasional (33%)] _____

How does the pain feel? (Sharp, dull, aching, stabbing, burning, etc.) _____

What makes the pain worse? _____

What decreases the pain? _____

Using the pain scale below, how would you describe your pain? Please circle the number that best estimates the amount of pain you are currently experiencing.

Before the injury: no pain ←----------→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Your pain now: no pain ←----------→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Does your present pain travel to other parts of the body? o yes o no
If yes, where? _____

Do you experience stiffness? o yes o no

Do you experience weakness? o yes o no

Do you experience numbness? o yes o no

Do you experience tingling? o yes o no If so, where? _____

Do you have swelling? o yes o no

Any popping of the joints? o yes o no

Any locking of the joints? o yes o no

Any giving way of joints? o yes o no

Have you had any hip injuries or surgeries? o yes o no If so, when? _____

BACK

Are you still having pain? o yes o no If so, which part? _____

Describe the pain: [Constant (100%), frequent (75%), intermittent (66%), occasional (33%)] _____

How does the pain feel? (Sharp, dull, aching, stabbing, burning, etc.) _____

What makes the pain worse? _____

What decreases the pain? _____

Using the pain scale below, how would you describe your pain? Please circle the number that best estimates the amount of pain you are currently experiencing.

Before the injury: no pain ←----------→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Your pain now: no pain ←----------→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Does your present pain travel to other parts of the body? o yes o no
If yes, where? _____

Do you experience stiffness? o yes o no

Do you experience weakness? o yes o no

Do you experience numbness? o yes o no If so, where? _____

Do you experience tingling? o yes o no If so, where? _____

Do you have swelling? o yes o no

Any giving way of joints? o yes o no

Any popping of the joints? o yes o no

Any locking of the joints? o yes o no

Do you have any problems walking? o yes o no

Do you have any problems bending/squatting/pushing/pulling? o yes o no

Do you have any problems lifting? o yes o no How much can you lift? _____

Do you have any bladder or bowel problems? o yes o no

Is there increased pain with coughing or sneezing? o yes o no

Do you use any assistive device(s)? (cane, support, corset, etc.) _____

KNEES

Are you still having pain? o yes o no If so, which knee? _____

Describe the pain: [Constant (100%), frequent (75%), intermittent (66%), occasional (33%)] _____

How does the pain feel? (Sharp, dull, aching, stabbing, burning, etc.) _____

What makes the pain worse? _____

What decreases the pain? _____

Using the pain scale below, how would you describe your pain? Please circle the number that best estimates the amount of pain you are currently experiencing.

Before the injury: no pain ←----------→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Your pain now: no pain ←----------→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Does your present pain travel to other parts of the body? o yes o no
If yes, where? _____

Do you experience stiffness? o yes o no

Do you experience weakness? o yes o no

Do you experience numbness? o yes o no

Do you experience tingling? o yes o no If so, where? _____

Do you have swelling? o yes o no

Any popping of the joints? o yes o no

Any locking of the joints? o yes o no

Any giving way of joints? o yes o no

Do you have any buckling of the knees? o yes o no

Does your knee feel stable? o yes o no

Do you have pain ascending and descending stairs? o yes o no

Do you have any surgeries? o yes o no If so, when? _____ What type? _____

ANKLE/FEET

Are you still having pain? o yes o no If so, which ankle/foot? _____

Describe the pain: [Constant (100%), frequent (75%), intermittent (66%), occasional (33%)] _____

How does the pain feel? (Sharp, dull, aching, stabbing, burning, etc.) _____

What makes the pain worse? _____

What decreases the pain? _____

Using the pain scale below, how would you describe your pain? Please circle the number that best estimates the amount of pain you are currently experiencing.

Before the injury: no pain ←----------→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Your pain now: no pain ←----------→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Does your present pain travel to other parts of the body? o yes o no
If yes, where? _____

Do you experience stiffness? o yes o no

Do you experience weakness? o yes o no

Do you experience numbness? o yes o no If so, which toes? _____

Do you experience tingling? o yes o no If so, which toes? _____

Do you have swelling? o yes o no

Any popping of the joints? o yes o no

Any locking of the joints? o yes o no

Any giving way of joints? o yes o no

Does you ankle feel stable? o yes o no

Do you have problems squatting, ascending and descending stairs? o yes o no

Do you have difficulty walking on uneven ground? o yes o no

Have you had prior injuries? o yes o no If yes, when? _____

Have you had prior surgeries? o yes o no If yes, when? _____

==========

Do you have difficulty sleeping due to pain? o yes o no

Please describe in your own words any other problems you are having at this time, which you relate to the accident: _____

_____

_____

What can't you do now that you could do before? _____

_____

Anything else you want to report: _____

_____

_____

_____

Activities of Daily Living (AMA Guides, Fifth Edition, Pg. 4, Table 1-2)

PLEASE CHECK THE APPROPRIATE BOX PER INQUIRY.

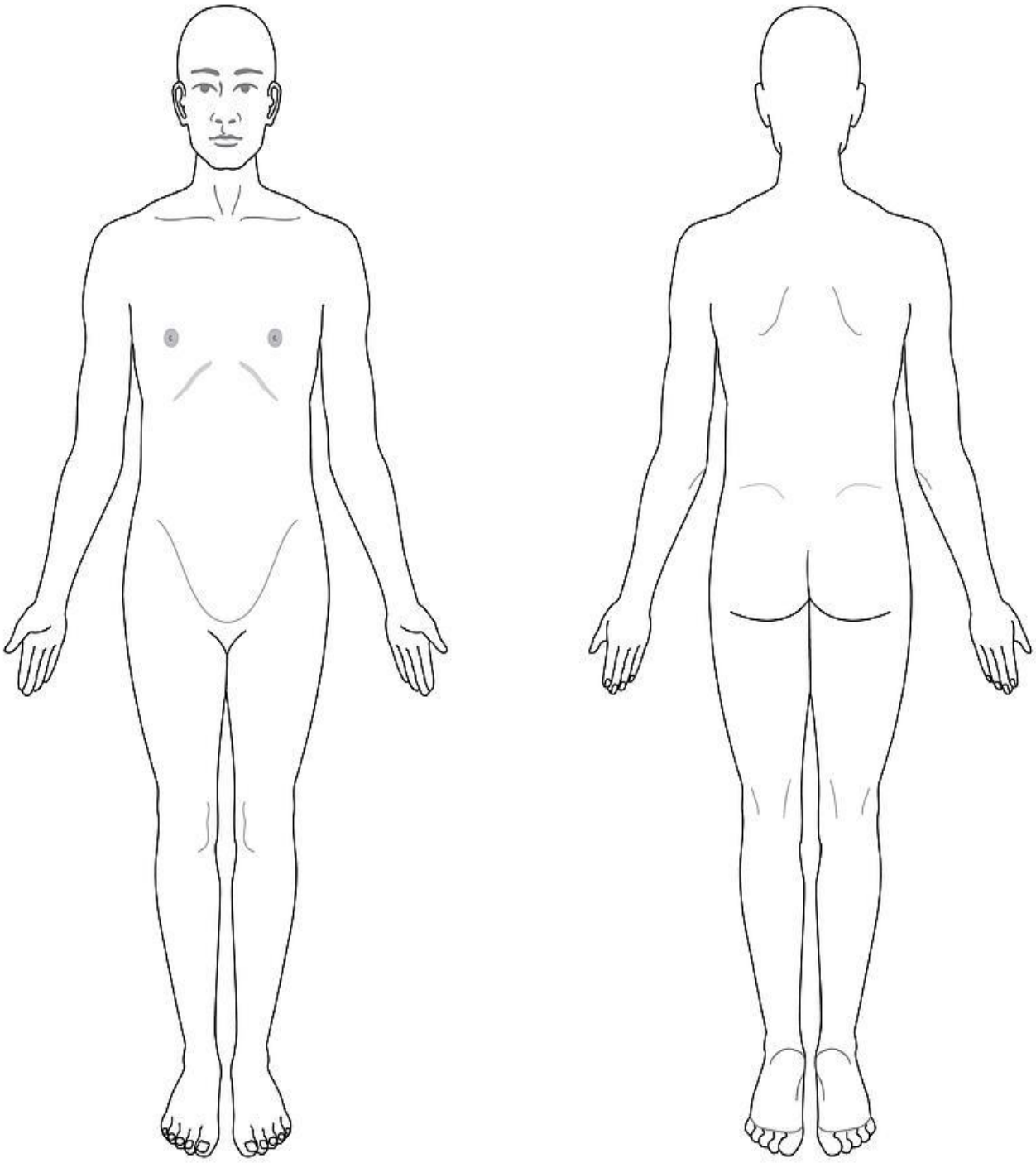
| | CATEGORY OF ACTIVITY | ACTIVITY | WITHOUT DIFFICULTY | WITH SOME DIFFICULTY | WITH MUCH DIFFICULTY | MOSTLY UNABLE TO DO |
|---|---|---|---|---|---|---|
| 1. | **SELF-CARE, PERSONAL HYGIENE** | Take a shower | | | | |
| | | Take a bath | | | | |
| | (BATHING, BRUSHING TEETH, COMBING HAIR, DRESSING ONESELF, EATING, URINATING, DEFECATING) | Wash & dry face | | | | |
| | | Wash & dry body | | | | |
| | | Turn on/off faucets | | | | |
| | | Brush teeth | | | | |
| | | Comb/brush hair | | | | |
| | | Dress self | | | | |
| | | Put on/off shoes/socks | | | | |
| | | Open carton of milk | | | | |
| | | Open a jar | | | | |
| | | Make a meal | | | | |
| | | Lift fork/spoon to mouth | | | | |
| | | Lift glass/cup to mouth | | | | |
| | | Get on/off toilet | | | | |
| | | Ablility to urinate | | | | |
| | | Ablility to defecate | | | | |
| | | Describe other: | | | | |

| | CATEGORY OF ACTIVITY | ACTIVITY | WITHOUT DIFFICULTY | WITH SOME DIFFICULTY | WITH MUCH DIFFICULTY | MOSTLY UNABLE TO DO |
|---|---|---|---|---|---|---|
| 2. | **PHYSICAL ACTIVITY** | Stand | | | | |
| | | Sit | | | | |
| | (STANDING, SITTING, RECLINING, WALKING, CLIMBING STAIRS, LIFTING) | Recline | | | | |
| | | Rise from a chair | | | | |
| | | Get in/out of bed | | | | |
| | | Climb flight of (10) stairs | | | | |
| | | Work outdoors | | | | |
| | | Light housework | | | | |
| | | Shop/do errands | | | | |
| | | Walk | | | | |
| | | Carry groceries | | | | |
| | | Lift 5 lbs. | | | | |
| | | Lift 10 lbs. | | | | |
| | | Lift 20 lbs. | | | | |
| | | Lift 30 lbs. | | | | |
| | | Care for children or parents | | | | |
| | | Engage in hobbies (music or crafts, etc.) indicate hobby: | | | | |
| | | Describe other: | | | | |
| 3. | **COMMUNICATION** | Write a note | | | | |
| | | Type a message on a computer / keyboard | | | | |
| | (WRITING, TYPING, SEEING, HEARING, SPEAKING) | See a television screen | | | | |
| | | Use a telephone | | | | |
| | | Speak clearly | | | | |
| | | Hear clearly | | | | |
| | | Describe other: | | | | |

| | CATEGORY OF ACTIVITY | ACTIVITY | WITHOUT DIFFICULTY | WITH SOME DIFFICULTY | WITH MUCH DIFFICULTY | MOSTLY UNABLE TO DO |
|---|---|---|---|---|---|---|
| 4. | **SENSORY FUNCTION**<br><br>(TACTILE FEELING, TASTING, SMELLING) | Feel what you touch | | | | |
| | | Taste what you eat | | | | |
| | | Smell what you eat | | | | |
| | | Describe Other: | | | | |
| 5. | **TRAVEL**<br><br>(RIDING, DRIVING, FLYING) | Get in/out of a car | | | | |
| | | Drive a car | | | | |
| | | Ride in a car | | | | |
| | | Ride a bicycle | | | | |
| | | Fly in a plane | | | | |
| | | Describe Other: | | | | |
| 6. | **SEXUAL FUNCTION**<br><br>(LUBRICATION, ERECTION, ORGASM, EJACULATION) | Engage in sexual activity | | | | |
| | | Describe Other: | | | | |

Indicate, with the following symbols, the kind of pain and where it is located:

Sharp pain = XXXXX
Dull pain = OOOOO
Numbness & Tingling = /////////



PAST MEDICAL HISTORY
(**per body part**)

NECK

Prior to the injury in question, have you ever had similar problems with, or injuries to, the neck involved in this claim? o yes o no

Was the prior injury work related? o yes o no
Was the prior injury non-work related? (i.e. auto accidents, slip or falls) o yes o no

If work related:
Who was your employer at the time? _____
Did you receive treatment? o yes o no Was a full recovery made? o yes o no
If yes, what type of treatment? _____
Was a Workers' Compensation case opened? o yes o no
If yes, is it settled? o yes o no If yes, how much was the settlement? _____

If non-work related:
Please explain what type of injury and date(s): _____
_____
_____
Did you receive treatment? o yes o no Was a full recovery made? o yes o no
If yes, what type of treatment? _____

SHOULDERS

Prior to the injury in question, have you ever had similar problems with, or injuries to, the shoulder(s) involved in this claim? o yes o no If yes, which shoulder? o Right o Left

Was the prior injury work related? o yes o no
Was the prior injury non-work related? (i.e. auto accidents, slip or falls) o yes o no

If work related:
Who was your employer at the time? _____
Did you receive treatment? o yes o no Was a full recovery made? o yes o no
If yes, what type of treatment? _____
Was a Workers' Compensation case opened? o yes o no
If yes, is it settled? o yes o no If yes, how much was the settlement? _____

If non-work related:
Please explain what type of injury and date(s): _____
_____
_____
Did you receive treatment? o yes o no Was a full recovery made? o yes o no

If yes, what type of treatment? _____

## ELBOWS

Prior to the injury in question, have you ever had similar problems with, or injuries to, the elbow(s) involved in this claim? o yes o no If yes, which elbow? o Right o Left

Was the prior injury work related? o yes o no
Was the prior injury non-work related? (i.e. auto accidents, slip or falls) o yes o no

If work related:
Who was your employer at the time? _____
Did you receive treatment? o yes o no Was a full recovery made? o yes o no
If yes, what type of treatment? _____
Was a Workers' Compensation case opened? o yes o no
If yes, is it settled? o yes o no If yes, how much was the settlement? _____

If non-work related:
Please explain what type of injury and date(s): _____
_____
_____
Did you receive treatment? o yes o no Was a full recovery made? o yes o no
If yes, what type of treatment? _____

## WRIST/HAND

Prior to the injury in question, have you ever had similar problems with, or injuries to, the wrist or hand(s) involved in this claim? o yes o no If yes, which wrist/hand? o Right o Left

Was the prior injury work related? o yes o no
Was the prior injury non-work related? (i.e. auto accidents, slip or falls) o yes o no

If work related:
Who was your employer at the time? _____
Did you receive treatment? o yes o no Was a full recovery made? o yes o no
If yes, what type of treatment? _____
Was a Workers' Compensation case opened? o yes o no
If yes, is it settled? o yes o no If yes, how much was the settlement? _____

If non-work related:
Please explain what type of injury and date(s): _____
_____
_____
Did you receive treatment? o yes o no Was a full recovery made? o yes o no
If yes, what type of treatment? _____

## HIPS

Prior to the injury in question, have you ever had similar problems with, or injuries to, the hip(s) involved in this claim? o yes o no If yes, which hip? o Right o Left

Was the prior injury work related? o yes o no
Was the prior injury non-work related? (i.e. auto accidents, slip or falls) o yes o no

If work related:
Who was your employer at the time? _____
Did you receive treatment? o yes o no Was a full recovery made? o yes o no
If yes, what type of treatment? _____
Was a Workers' Compensation case opened? o yes o no
If yes, is it settled? o yes o no If yes, how much was the settlement? _____

If non-work related:
Please explain what type of injury and date(s): _____
_____
_____
Did you receive treatment? o yes o no Was a full recovery made? o yes o no
If yes, what type of treatment? _____

## BACK

Prior to the injury in question, have you ever had similar problems with, or injuries to, the back involved in this claim? o yes o no If yes, upper back or lower back? _____

Was the prior injury work related? o yes o no
Was the prior injury non-work related? (i.e. auto accidents, slip or falls) o yes o no

If work related:
Who was your employer at the time? _____
Did you receive treatment? o yes o no Was a full recovery made? o yes o no
If yes, what type of treatment? _____
Was a Workers' Compensation case opened? o yes o no
If yes, is it settled? o yes o no If yes, how much was the settlement? _____

If non-work related:
Please explain what type of injury and date(s): _____
_____
_____
Did you receive treatment? o yes o no Was a full recovery made? o yes o no
If yes, what type of treatment? _____

## KNEES

Prior to the injury in question, have you ever had similar problems with, or injuries to, the knee(s) involved in this claim? o yes o no If yes, which knee? o Right o Left

Was the prior injury work related? o yes o no
Was the prior injury non-work related? (i.e. auto accidents, slip or falls) o yes o no

If work related:
Who was your employer at the time? _____
Did you receive treatment? o yes o no Was a full recovery made? o yes o no
If yes, what type of treatment? _____
Was a Workers' Compensation case opened? o yes o no
If yes, is it settled? o yes o no If yes, how much was the settlement? _____

If non-work related:
Please explain what type of injury and date(s): _____
_____
_____
Did you receive treatment? o yes o no Was a full recovery made? o yes o no
If yes, what type of treatment? _____

## ANKLE/FEET

Prior to the injury in question, have you ever had similar problems with, or injuries to, the ankle or feet involved in this claim? o yes o no If yes, o Right o Left

Was the prior injury work related? o yes o no
Was the prior injury non-work related? (i.e. auto accidents, slip or falls) o yes o no

If work related:
Who was your employer at the time? _____
Did you receive treatment? o yes o no Was a full recovery made? o yes o no
If yes, what type of treatment? _____
Was a Workers' Compensation case opened? o yes o no
If yes, is it settled? o yes o no If yes, how much was the settlement? _____

If non-work related:
Please explain. Was it a fracture, sprain? _____
_____
_____
Did you receive treatment? o yes o no Was a full recovery made? o yes o no
If yes, what type of treatment? _____

**********

## MEDICAL HISTORY

Do you have any medical problems or serious illnesses you are being treated for (i.e. diabetes mellitus, high blood pressure, asthma, cancer, high cholesterol, etc)? _____
_____
_____

What medications are you currently taking, or have recently taken? (Over-the-counter and/or prescription)_____
_____

Have you had any surgeries? If so, please describe: _____
_____
_____

Have you been hospitalized for any treatment? If so, please describe: _____
_____
_____

Do you have any allergies to medication? o yes o no If yes, list: _____
_____

Check below if you have had any of the following diseases/illnesses as a child or as an adult:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Anemia | | Diabetes | | Kidney Disease | | Epilepsy/Seizures | |
| Asthma | | Pneumonia | | Fracture | | Hepatitis/Jaundice | |
| Cancer | | Chicken Pox | | Tuberculosis | | High Blood Pressure | |
| Hernia | | Skin Problems | | Rheumatic Fever | | Gallbladder | |
| Polio | | Stool Disorders | | Thyroid Disorder | | Bleeding Disorder | |
| Ulcer | | Mental Disorder | | Arthritis | | Other | |
| Sexually Transmitted Disease | | | | Heart Disease | | Describe: | |

## PATIENT PROFILE

Marital Status: o Married o Single o Separated o Divorced o Widowed

Number of children _____ Age range _____ Do they live with you? o yes o no

Years of education completed: _____ College Degree(s) _____
Special Training _____

Did you serve in the U.S. Military? o yes o no If yes, what branch? _____
Dates _____

Do you smoke cigarettes? o yes o no If yes, how much? _____

Do you drink alcoholic beverages? o yes o no If yes, how often? _____
Do you use any street/illegal drugs? o yes o no Comment: _____
_____
_____

Do you have any history of drug or alcohol habit, dependency or abuse? o yes o no
Comment: _____
_____

Do you have any hobbies, special skills, or interests? o yes o no If yes, describe: _____
_____
_____

Do you participate in a fitness program or any sports activities? o yes o no If yes, describe:
_____
_____

Has the injury in question hindered or stopped you from doing any of your usual activities? o yes o no
If yes, please explain your reasons why: _____
_____
_____

SYSTEMS REVIEW

Circle below if you have any of the following problems:

| **Heart/Circulation** | **Bones/Joints** | **Stomach/Abdomen** | **Urogenital** |
|---|---|---|---|
| High Blood Pressure | Joint Pain | Nausea/Vomiting | Blood in Urine |
| Chest Pain | Joint Swelling | Peptic Ulcer Disease | Frequency/Urgency |
| Heart Attack | Stiffness | Pain | Getting up at Night |
| Swollen Feet | | Sudden Weight Loss | Discharge |
| Poor Healing | | Change in Bowel Habits | |
| | | Hernia | |
| **Neurological** | **Gynecological** | | |
| Numbness/Tingling | Pelvic Pain | | |
| Headaches | | | |
| Coordination Problems | **Emotional/Psychological** | | **Other:** |
| Double Vision | Depression | Thoughts of Suicide | |
| Memory Loss | Anger | Loss of Appetite | |
| | Anxiety | Unusual stress | |

**PATIENT STATEMENT**

The information given in this history questionnaire was provided by me or (  ) through an interpreter, and is true.

Patient's Signature: _____

Printed Name: _____

Date: _____

Interpreter: _____ Agency: _____