1400 Brandywine Boulevard
Zanesville, OH 43701
Phone: 740-450-9000
Fax: 740-450-2494

PATIENT QUESTIONAIRE

Patient Name:_____ Date:_____

Address: _____ City: _____ Zip: _____

Home Phone:_____ Cell: _____ Work:_____

Email Address:_____ Referred By:_____

Social Security: _____ DOB ____/____/____ Sex: Male / Female

Height:_____Width:_____Family Physician: _____

Chief Complaint:_____

Current Medication /Dosage:

1._____

2._____

3._____

4._____

5._____

6._____

7._____

Allergies including food:

1._____

2._____

3._____

4._____

Do you have insurance?_____ Policy ID #_____Group_____

Insurance Company:_____ Address_____

Insured's Name:_____ Relationship_____

SS# _____ DOB of insured: _____

I certify I have read this from and understand its contain:

Signature: _____ Date: _____

1400 Brandywine Boulevard
Zanesville, OH 43701
Phone: 740-450-9000
Fax: 740-450-2494

PAST SURGIAL HISTORY:

SPINE: _____

_____

JOINT: _____

_____

OTHER:_____

_____

_____

TOBACCO USAGE (per day): _____ QUIT DATE: _____

ALCOHOL USAGE (per day): _____ QUIT DATE: _____

RECREATIONAL DRUGS: ___Yes ___No ADDICTIONS: _____

FAMILY HISTORY: List by family: Diabetes/Heart Attack/Smoking/Hypertension/Cancer/Migraines/ Arthritis/Rheumatoid Arthritis/COPD/ Neurologic Disorders/Spine Pain/Depression/Parkinson's

Paternal Mother:

Paternal Father:

Maternal Mother:

Maternal Father:

DEVELOPMENTAL HISTORY: Circle One

Highest level of education: 7 8 9 10 11 12 GED Associate Bachelor Master PHD

Any difficulty reading or writing?_____

1400 Brandywine Boulevard
Zanesville, OH 43701
Phone: 740-450-9000
Fax: 740-450-2494

REVIEW OF SYSTEMS (check all that apply)

Patient Name_____ Date_____

GENERALS/METABOLIC: fevers___, chills___, weight loss___, gain___, heat/cold intolerance___, night sweats___ , decreased appetite___ , general weakness___, abnormal thirst___, malaise (generally not feeling good)___. Decreased sex drive or erectile dysfunction___.

HEAD/EYE/EARS/NOSE/THROAT: double vision___, blurry vision___, fishing lights, vision loss___, eye pain___, dry eyes___, sinusitis___, nose bleeds___, persistent mouth sores___, persistent hoarseness___, ringing in ears___.

RESPIRATORY: persistent cough___, wheezing___, smoker's cough___, coughing blood___, shortness of breath___, nighttime coughing___, snoring___, sleep apnea (gasping for breath night)___.

CARDIOVASULAR: chest pain___, palpitation___, rapid heartbeats___, chest tightness___, shortness of breath with/without exertion___, swelling of legs(edema)___, loss of consciousness (syncope)___, orthopnea (need to prop up with pillows to breathe)___.

GASTROINTESTINAL: dark tarry stools___, blood in stool___, abdominal Pain/cramps___, vomiting blood___, nausea/vomiting ___, acid reflux/heart burn___, irritable bowel___, jaundice (yellow skin/eyes) ___, difficulty/pain with swallowing___.

GENITOURINARY/RENAL: pain on sexual activity___, blood in urine ___, urine accidents (incontinence) with/without cough___, pelvic pain___, vaginal discharge___, kidney/bladder stones/cramping flank pain___, burning with urination___, frequent nighttime urination___.

MUSCLOSKELETAL/RHEUMATOLOGIC: general muscle aches and pain___, muscle cramps ___, night cramps___, swollen hands/fingers/feet___, red/swollen joints___, migratory pain (moves from place to place) ___, posture problem ___, muscle weakness___, difficulty bearing weight on lower extremities___. Unusual masses/nodules on extremities___.

NEUROLOGIC: dizziness___, headaches___, facial pain___, confusion___, seizures___, head trauma___, loss of balance/frequent falls___, memory loss___, speech difficulties___, areas of numbness/tingling___, shooting/electric pains___, burning hand/foot pain___.

DERMATOLOGIC: rashes___, tumors___, hair loss___, poor skin healing___, skin infections___, herpes zoster (shingles) ___.

PSYCHITRIC: anxiety/nervousness___, depression___, panic attacks___, sleeplessness___, poor sleep initiation___, post-traumatic street disorder___, claustrophobia___, bipolar disorder___, personality disorder ___.

HEMATIOLOGIC/ONCOLOGIC: easy bleeding___, easy bruising___, cancer history___.