Rowan Medicine

NMI: Health History Questionnaire

NAME:_____AGE:_____D.O.B. _____TODAY'S DATE:_____

CURRENT PROBLEM (REASON FOR VISIT):_____

HOW LONG HAVE YOU HAD THIS CONDITION?:_____

HOW HAS IT PROGRESSED?:_____

PRIOR TREATMENTS FOR THIS CONDITION:_____

-Physical Therapy Y / N. If yes, last date of treatment and effect? : _____

_____

-Prior Injections? Y / N. If so, what kind and who administered them?

_____

_____

_____

PRIOR IMAGING FOR THE ABOVE CONDITION: X-ray / MRI / CT ? Approx. When? _____ What Facility? _____

PLEASE LIST MEDICATIONS (WITH DOSAGES) YOU ARE CURRENTLY TAKING (If you need more space please use the separate Medication List included in your packet):

_____

_____

_____

PLEASE LIST **ALL** ALLERGIES AND WHAT TYPE OF REACTION YOU EXPERIENCE:

_____

_____

_____

DO YOU USE ANY ASSISTIVE DEVICES (CANE, WALKER, ORTHOTICS, BRACE, OR WHEELCHAIR)?

_____

WHO DO YOU LIVE WITH?:_____

ARE YOU CURRENTLY EMPLOYED, Y / N? IF YES, FULL OR PART-TIME? _____OCCUPATION: _____

IF NO, ARE YOU ON DISABILITY Y / N? SINCE WHEN? _____

_____

DO YOU SMOKE?_____ How much? _____HOW MUCH ALCOHOL DO YOU DRINK WEEKLY?_____

NEUROMUSCULOSKELETAL INSTITUTE

PAST MEDICAL HISTORY, HAVE YOU EVER EXPERIENCED PROBLEMS WITH:

☐ HEART DISEASE	☐ LUNG DISEASE	☐ BLOOD CLOTS	☐ HEART ATTACK
☐ DIABETES	☐ ARTHRITIS	☐ STROKE	☐ STOMACH ULCERS
☐ HEPATITIS	☐ THYROID DISEASE	☐ LIVER/KIDNEY	☐ CANCER
☐ NERVE DAMAGE	☐ MUSCLE WEAKNESS		

IN THE LAST 2 YEARS HAVE YOU BEEN HOSPITALIZED, Y / N? If yes, approximately when and what hospital:_____

_____

HAVE YOU HAD ANY INJURIES?_____

_____

HAVE YOU EVER EXPERIENCED PROBLEMS WITH (CHECK ALL THAT APPLY):

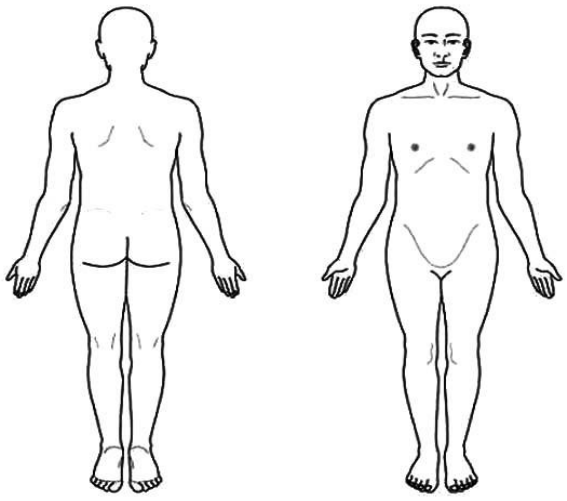
☐ HEADACHES	☐ CHEST PAINS	☐ WEAKNESS	☐ FEVER
☐ BLURRING VISION	☐ HEART SKIPPING BEAT	☐ LEG CRAMPS	☐ NUMBNESS/TINGLING
☐ DIZZINESS	☐ SHORTNESS OF BREATH	☐ FALLING	☐ BOWEL PROBLEMS
☐ TIREDNESS	☐ HEARTBURN	☐ DIFFICULTY WALKING	☐ URINARY DIFFICULTY
☐ DIFFICULTY SWALLOWING	☐ PERSISTENT COUGH	☐ DROPPING THINGS	☐ BLOOD IN URINE/STOOL
☐ DRY MOUTH	☐ SPITTING BLOOD	☐ SWOLLEN/PAINFUL JOINTS	☐ WEIGHT CHANGE

PAIN HISTORY:

LOCATION: Where is your pain located? Mark on the drawing below the exact position of your pain with an "X".

- o Headache
- o Facial Pain
- o Neck Pain
- o Shoulder Pain ☐ Left ☐ Right
- o Upper Extremity Pain ☐ Left ☐ Right
- o Upper Back Pain
- o Low Back Pain
- o Hip Pain ☐ Left ☐ Right
- o Lower Extremity Pain ☐ Left ☐ Right
- o Joint Pain: Which Joint(s)?

_____



NEUROMUSCULOSKELETAL INSTITUTE

ONSET & DURATION: When did your pain start and how long has it been bothering you?

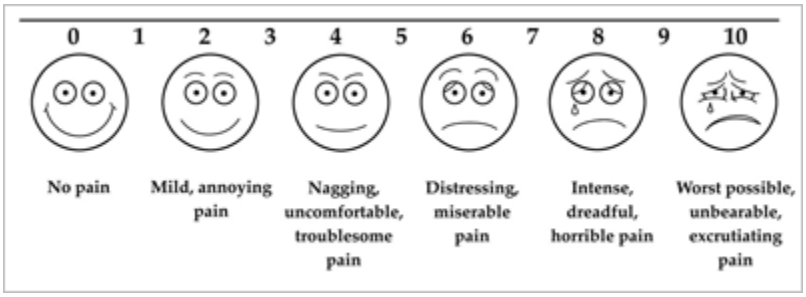
_____

_____

How did your pain start? _____

_____

SEVERITY: How bad is your pain on a **0-10** scale? 0 being no pain and 10 being the worst imaginable pain: _____/ 10



QUALITY: What type of pain are you having? Please circle all that apply:

Dull Sharp Shooting Squeezing Crushing Stabbing Burning Throbbing

ASSOCIATIONS: Is your pain associated with the following? Circle all that apply:

Nausea Vomiting Headache Photophobia (light bothering eyes) Muscle Cramps

AFFECT: What does your pain affect? Circle all that apply and state how:

Functional level: _____ Mood: _____

Sleep: _____ Sexual function: _____

If there is any additional information you would like to provide, please do so here:

_____

_____

_____

_____

Physician Reviewing: _____Date:_____