



Initial and Interval History Questionnaire
(Completed at first visit and updated yearly by patient)

Date:
Patient Name:
Patient address:
DOB:
Patient SS#:
Phone #:

Visit Type:
Company Name:
Company Address:
Company Contact:
Company Phone #:
Cell Phone #:

1. Why are you seeing the clinician today? _____
2. List any illnesses or injuries you are currently being treated for such as high blood pressure, heart disease, asthma, high cholesterol, weight management, diabetes, migraines, etc.

3. List your hobbies: _____
4. If you are currently taking any prescription medicine, over-the-counter medicine, vitamins, herbs, nutritional supplements or birth control pills, please list them below:

5. List any medications that you are allergic to and your reaction, e.g. hives, rash, etc.

6. List any non-medication allergies such as foods, grass, mold, iodine, etc.

7. List any serious illness or conditions you had as a child: _____
8. When was your last tetanus booster? _____
9. Do you smoke? Yes () No () If yes, what do you smoke? _____
Amount per day? _____ Number of years you have smoked? _____
10. How many alcoholic beverages do you drink per week? _____
11. For females only, date of last normal period: _____ currently pregnant? Yes () No ()
12. If you have had any surgeries, hospitalizations or have missed more than 5 days of work due to an illness or injury, please describe below. Please include month and year:

13. Have you ever received workers' compensation? Yes () No ()
If yes, for what reasons: _____

14. OCCUPATIONAL HISTORY: Please list your job titles over the past 10 years. List your current job first:

Have you been exposed to any of the following while working or at home?

Chemicals () Lead () Gases () Fumes () Second hand smoke () Loud Noise () Asbestos ()

Do you use any of the following protection at work or for home use?

Respirator () Safety Glasses () Hearing protection () Steel tipped boots ()

15. MEDICAL HISTORY: Have you had any of the following tests? If yes, for what reason?

MRI () X-Ray () EKG () Stress Test () Lung Testing () Test for stomach problem ()

Reason for test (s): _____

Are you missing any body parts? Yes () No ()

Are you (check one) right handed _____ or left handed _____

Review of Systems

Please check below any of the conditions or symptoms that you are experiencing:

Vision: ALL NEGATIVE () Wear glasses/contact () Tearing () Blurred Vision ()

Hearing: ALL NEGATIVE () Loss of Hearing () Ringing of ears ()

Neurological: ALL NEGATIVE () Headaches () Dizziness () Stroke () Numbness or Tingling ()

Head injury () Seizures () Tremors () Problems sleeping ()

Other: _____

Musculoskeletal: ALL NEGATIVE () Fracture () Back pain () Shoulder Pain () Knee Pain () Wrist Pain ()

Ankle pain () Neck Pain () Joint Pain () Unsteady Walking ()

Other: _____

Cardiovascular: ALL NEGATIVE () High Blood Pressure () Heart Attack () Chest Pain () Palpitations ()

Other: _____

Respiratory: ALL NEGATIVE () Asthma () Lung Cancer () Emphysema () Cough () Shortness of Breath ()

Other: _____

Circulatory: ALL NEGATIVE () Swelling of the Hands/Feet () Blood Clots () Sickle Cell Anemia ()

Other: _____

Endocrine: ALL NEGATIVE () Thyroid Problems () Changes in Weight > than 10 lbs in < 1 year () Diabetes ()

Other: _____

GI: ALL NEGATIVE () Stomach Ulcers () Blood in Stool () Gallstones () Hernia () Hepatitis ()

Other: _____

Emotional: ALL NEGATIVE () Anxiety Disorder () Depression () Mood Disorder () Panic Attacks ()

Other: _____

I certify that this information is correct to the best of my knowledge.

Patient's Signature

Date

Clinician's Notes:

Reviewed by: _____ Date: _____