HAWAII INJURY RECOVERY CENTER

Patient History Questionnaire

Name:_____ DOB:____/____/_____

Referring MD:_____ Today's Date:___/___/___

Primary MD:_____

_____

Past Medical History:

- ▫ High Blood Pressure
- ▫ Diabetes
- ▫ High Cholesterol
- ▫ Heart Disease
- ▫ Heart Arrhythmia
- ▫ Trouble Breathing
- ▫ Stroke
- ▫ Seizure
- ▫ Other
- ▫ Thyroid Dysfunction
- ▫ Bleeding Disorder
- ▫ Cancer
- ▫ Head Injury
- ▫ HIV
- ▫ Hepatitis
- ▫ Heartburn
- ▫ Previous Injuries Requiring Treatment
- ▫ Kidney Dysfunction
- ▫ Liver Dysfunction
- ▫ Anemia
- ▫ Headache
- ▫ Completed Menopause
- ▫ Currently Pregnant
- ▫ Stomach Ulcer

Past Surgical History:

- ▫ Neck Surgery
- ▫ Low Back Surgery
- ▫ Joint Surgery
- ▫ Other

Family History:

- ▫ High Blood Pressure
- ▫ High Cholesterol
- ▫ Other
- ▫ Diabetes
- ▫ Heart Disease
- ▫ Stroke
- ▫ Cancer

Social History:

- ▫ Tobacco
- ▫ Married
- ▫ Work/Occupation: (please describe)
- ▫ Alcohol
- ▫ Children
- ▫ Recreational Drugs

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Current Medications: (amount, times taken per day, only as needed, etc)

Medications Tried In The Past For This Problem: (Reason why you stopped taking them)

Medication Allergies: (and what the allergic reaction is)

Previous Treatments Tried For This Problem: (Physical Therapy, Chiropractor, Acupuncture, etc)

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