UCLA Health

MRN:
Patient Name:

PATIENT MEDICAL HISTORY QUESTIONNAIRE

Occupation: _____ Email: _____

Referring Physician Name: _____ Phone: _____

Address _____City_____State_____Zip_____

Height _____ Weight _____ Are you right or left-handed? ☐ Right ☐ Left

Chief Complaint/Why are you here today? _____

Was there an injury? ☐ Yes ☐ No If yes, how did you get injured? – Describe below:

_____

Date of injury/Onset of condition: _____

Is this a work related injury? ☐ Yes ☐ No Was it reported? ☐ Yes ☐ No

Where is the pain/problem? _____

Does it travel to other areas? ☐ Yes ☐ No If yes, where? _____

How long has it been hurting? _____weeks(s) _____ month(s) _____year(s)

Rate your pain on a scale of 1-10, 10 being worst, please check:
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Quality of pain: ☐ Dull ☐ Throbbing ☐ Sharp | If lump, is it ☐ warm ☐ tender ☐ red

The pain is: ☐ getting better ☐ staying the same ☐ getting worse

What makes the pain better? _____Worse? _____

Activities you can no longer perform due to this injury? _____

Associated symptoms: ☐ popping ☐ clicking ☐ swelling ☐ grinding ☐ Other _____

Have you seen any **other** physicians for treatment regarding this condition? ☐ Yes ☐ No

If yes, what is the physician's name? _____

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Which of the following treatments have you had for **this** problem? ☐ None		Did it help?
☐ Medications	Duration:	☐ Yes ☐ No
☐ Physical Therapy	Duration:	☐ Yes ☐ No
☐ Injections	Quantity:	☐ Yes ☐ No
☐ Brace		☐ Yes ☐ No
☐ Crutches		☐ Yes ☐ No
☐ Other:		
Surgery Date:	What type of Surgery?	☐ Yes ☐ No
Surgery Date:	What type of Surgery?	☐ Yes ☐ No

What type of test(s) have you had? ☐ None

	Date	Location
☐ MRI		
☐ X-ray		
☐ Ultrasound		
☐ EMG/NCV		

PAST HISTORY OF PRESENT ILLNESS

Have you had any previous injury to this area? ☐ Yes ☐ No

Hobbies/Sports: _____

☐ AIDS or HIV+	☐ Chronic Pain (CRPS)	☐ Neuropathy
☐ Anemia	☐ COPD	☐ Peripheral vascular disease
☐ Anxiety	☐ Deep venous thrombosis	☐ Polio
☐ Arthritis	☐ Depression	☐ Pulmonary embolism
☐ Asthma	☐ Diabetes	☐ Rheumatoid arthritis
☐ Auto-immune disorder	☐ Epilepsy/Seizures	☐ Sleep apnea
☐ Back trouble	☐ Fibromyalgia	☐ Stroke
☐ Bleeding tendency	☐ Gastro esophageal reflux	☐ Thyroid disease
☐ Blood transfusions	☐ Gout	☐ Tuberculosis
☐ Bronchitis	☐ Heart disease	☐ Ulcer
☐ Cancer	☐ Hepatitis - ☐ A ☐ B ☐ C	☐ Valley fever
Type: _____	☐ High blood pressure	☐ Venereal disease
Location/Treatment Received:	☐ Kidney disease	☐ Other (please list):
_____	☐ Lupus	
☐ Chemo ☐ Surgery	☐ Lyme disease	
☐ Radiation	☐ Mitral valve prolapse	

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Medications: Include non-prescription and herbal supplements (use reverse side of form if needed). ☐ Please see attached ☐ Please see reverse side

Drug Name	Dosage	Frequency	Oral	Topical	Injection	IV	Other
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	

Drug Allergies: ☐ No known drug allergies

Medication	Reaction	Mild	Moderate	Severe	Unknown
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

Tape Allergy: ☐ Yes ☐ No **Latex Allergy:** ☐ Yes ☐ No

Have you ever been diagnosed with osteoporosis or osteopenia? ☐ Yes ☐ No

Have you had a Bone Mineral Density Test (DEXA)? ☐ Yes ☐ No
If yes, date of last test:

What were the results?

Post-Surgical/Hospitalization History (use reverse side if needed):

Date	Surgery/Illness	Doctor	Hospital/City/State

Patient Social History

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

Use of Tobacco	Use of Alcohol
☐ Never	☐ Never ☐ Occasional ☐ Moderate ☐ Daily
☐ Former smoker Start Date: Quit date:	Number of times this past year you have had: 5 or more drinks in one day? 4 or more drinks in one day?
☐ Current daily smoker Start Date: Quit date:	Living Situation:
☐ Current occasional smoker Start Date: Quit date:	☐ with family ☐ with friends ☐ alone ☐ other:

Family History

	Age	Conditions/Diseases	If deceased, cause of death
Father			
Mother			
Siblings			

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REVIEW OF SYSTEMS: Please check all that apply:

Musculoskeletal	Yes	No
Joint pain	☐	☐
Joint stiffness	☐	☐
Weakness of muscles or joints	☐	☐
Muscle pain or cramps	☐	☐
Back pain	☐	☐
Cold extremities	☐	☐
Difficulty in walking	☐	☐

Constitutional Symptoms	Yes	No
Bad general health	☐	☐
Recent wt change	☐	☐
Fever	☐	☐
Fatigue	☐	☐
Headaches	☐	☐

Ears/Nose/Mouth/ Throat	Yes	No
Hearing loss/ringing	☐	☐
Ear aches/drainage	☐	☐
Chronic sinus problems	☐	☐
Nosebleeds	☐	☐
Bleeding gums	☐	☐
Sore throat or voice change	☐	☐
Swollen glands in neck	☐	☐

Cardiovascular	Yes	No
Heart trouble	☐	☐
Chest pain or angina pectoris	☐	☐
Palpitations	☐	☐
Shortness of breath while walking	☐	☐
Swelling feet/hands	☐	☐
Increased cholesterol	☐	☐

Genitourinary	Yes	No
Frequent urination	☐	☐
Burning or painful urination	☐	☐
Blood in urine	☐	☐
Incontinence of dribbling	☐	☐
Female # of pregnancies: ___		
Female # of deliveries: _____		

Integumentary (skin, breast)	Yes	No
Rash or itching	☐	☐
Change in skin color	☐	☐
Varicose veins	☐	☐
Breast pain	☐	☐
Breast lump	☐	☐

Neurological	Yes	No
Lightheaded/dizzy	☐	☐
Numbness/tingling	☐	☐
Tremors	☐	☐
Paralysis	☐	☐

Endocrine	☐	☐
Excessive thirst/ urination	☐	☐
Heat or cold intolerance	☐	☐
Skin becoming drier	☐	☐

Hematologic/ Lymphatic	Yes	No
Slow to heal after cuts	☐	☐
Bleeding/ bruising tendencies	☐	☐
Anemia	☐	☐
Enlarged glands	☐	☐

Psychiatric	Yes	No
Memory loss or confusion	☐	☐
Nervousness	☐	☐
Depression	☐	☐
Insomnia	☐	☐

Gastrointestinal	Yes	No
Loss of appetite	☐	☐
Nausea/vomiting	☐	☐
Frequent diarrhea	☐	☐
Constipation	☐	☐
Rectal bleeding/ bloody stool	☐	☐
Abdominal pain	☐	☐

Respiratory	Yes	No
Chronic/frequent coughs	☐	☐
Spitting up blood	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐

Eyes	Yes	No
Eye disease or injury	☐	☐
Wear glasses/ Contact lenses	☐	☐
Blurred or double vision	☐	☐

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Allergic/Immunologic – List food environmental allergies:

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

Patient or Representative Signature _____ Date _____ Time _____

If signed by someone other than the patient, please specify relationship to patient: _____

Interpreter Signature _____ Date _____ Time _____

Interpreter ID # _____