C. Daniel Smith, D.O.
Brett A. Miller, M.D.
Corey A. Trease, M.D.
Brian R. Duncan, M.D.

Blake E. Peterson, M.D.
J. Michael Smith, M.D.
John D. Weitlich, M.D.

Dr.______________________

Today's Date:______________

PATIENT HEALTH QUESTIONNAIRE

Name:______________________________ **D.O.B.:**____________ **Age**______ **Male**____ **Female**____

Have you ever been seen in the office before? Yes No

Is this injury or problem work related? Yes No

Referred by: (check one):
____Self ____Family ____Friend ____Doctor ____Other Health Professional ____Attorney

Name of person making referral:______________________________
Name of Primary Care Physician:______________________________

What is the nature of your injury or problem?______________________________

DATE OF INJURY OR ONSET OF CURRENT PROBLEM:______________

Please describe the reason for your visit today:
____
____
____

Your pain level now (circle one)	0	1	2	3	4	5	6	7	8	9	10
	No pain				Moderate pain					Severe pain	

Describe your pain (check all that apply)

Sharp	________	Constant	________	Wakes me up at night	________
Stabbing	________	Worse with activity	________	Getting better	________
Dull	________	Only with activity	________	Getting worse	________
		Relieved with rest	________	Staying the same	________

Please describe any previous treatment for this problem (please include physical therapy, surgery, injections, medications, etc.):
____
____

NURSING ONLY: PLEASE DO NOT WRITE IN THIS BOX

Ht:________ **Wt:**________ **Pulse:**________ **Resp Rate:**________ **RHD**________ **LHD**________
ASSESSMENT:______________________________
____
____
____
____
____

KNEE:
Popping:____ **Swelling:**____ **Locking:**____ **Give way:**____ **Limp:**____

Continued on back of page

Patient Name_______________________________

PAST MEDICAL HISTORY & SYSTEMS REVIEW (check all that apply):

Headaches	________	Cancer	________	Convulsions	________
Blurred Vision	________	Kidney Disease	________	Seizures	________
Hearing loss	________	Yellow Jaundice	________	Anxiety	________
Fainting episodes	________	Venereal Disease	________	Depression	________
Chest Pain	________	Tuberculosis	________	Thyroid problems	________
Angina	________	Bronchitis	________	Diabetes	________
Rheumatic Fever	________	Shortness of Breath	________	Hepatitis	________
High Blood Pressure	________	Emphysema	________	Blood Transfusion	________
Heart Attack	________	Poor circulation	________	Blood Disorders	________
Swollen Ankles	________	HIV/AIDS	________	Pregnancy	________
Skin Problems	________	Incontinence	________	Diarrhea/Constipation	________

List any additional Medical Problems below:

_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________

PAST SURGICAL HISTORY:

Previous Operations: Approximate Year

1. ____ ____________________
2. ____ ____________________
3. ____ ____________________
4. ____ ____________________
5. ____ ____________________

Any previous fractures? ____Yes ____No If yes, please describe:______________________

Any serious injuries? ____Yes ____No If yes, please describe:______________________

MEDICATIONS:

Drug Allergies (please circle): NO YES (if yes please list which medicines)____________________

Please list your current medications and dosage:

Name of Drug	Dose

SOCIAL HISTORY:

Occupation: ____________________________________ Job Duties:______________________

Do you smoke? ____Yes ____No ____In the past If yes, how much?____________________

Do you drink alcohol? ____Yes ____No

Do you regularly wear your seat belt? ____Yes ____No

FAMILY HISTORY (any history of parents or siblings with serious medical conditions): NO YES

If yes, please list which family member and their medical problem______________________

DOCTOR ONLY: PLEASE DO NOT WRITE IN THIS BOX.

I have reviewed this information with the patient:

Doctor's Signature:______________________________ Date:____________________