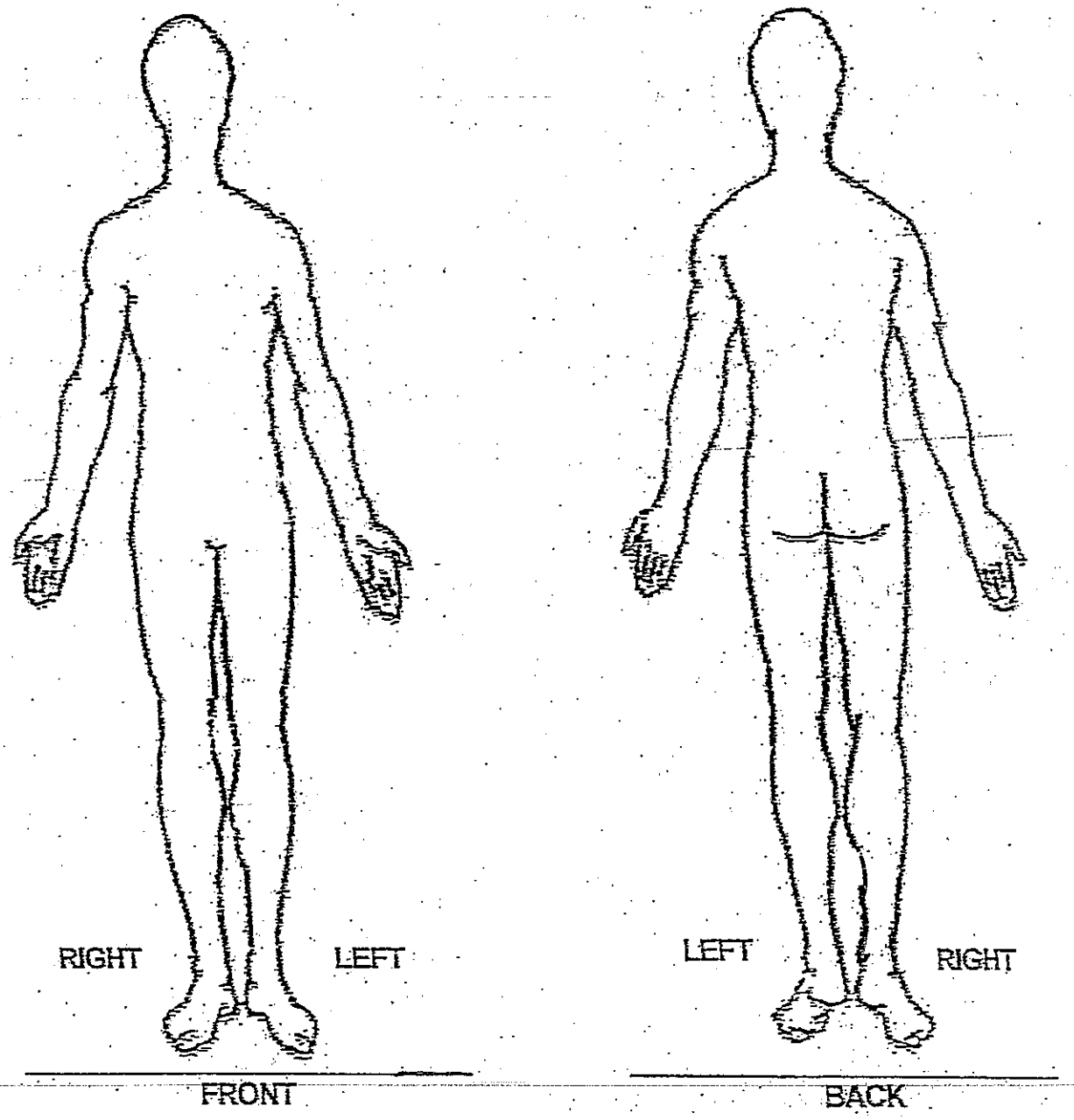
INITIAL MEDICAL QUESTIONAIRRE

Patient:_____Date:_____ Chart No.:_____

WHERE IS YOUR PAIN NOW?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas.

ACHING	NUMBNESS	PINS AND NEEDLES	BURNING	STABBING
▲▲▲	= = =	O O O	X X X	/ / /



HOW BAD IS YOUR PAIN NOW?

Please mark with an **X** on the pain drawing where the pain is worst now.

Where is the pain today? _____

Is your pain today: Same Better Worse compared to when it began?

What activities make it worse? (Please Circle)

Exercise (during)	Standing	Bending backward	Reaching
Exercise (after)	Walking	Coughing	Lifting
Sitting	Bending forward	Sneezing	
Driving			

What reduces the pain? (Please Circle)

Lying down	Manipulation	Muscle relaxant pills
Sitting	Home exercises	Aspirin/Anti-inflammatory pills
Standing	Exercises in physical therapy	Nothing
Walking	Pain pills	Heat / Ice
Injections for pain	Other _____	

What is the time interval between attacks of pain?

Constantly Daily Weekly Monthly Yearly

Have you been in constant pain since it began or is your pain intermittent? Describe _____

Have you noticed any: Numbness Tingling

Do your arms/legs get weak with your pain? _____

Do you have full control of your bladder and bowels? _____

Do you experience pain with sexual activity? Yes NO

Choose the number of the word which best describes your pain:

0	2	4	6	8	10
NONE	MILD	DISCOMFORTING	DISTRESSING	HORRIBLE	EXCRUCIATING

PATIENT _____ DATE _____ CHART # _____

PAST MEDICAL HISTORY

CIRCLE IF YOU CURRENTLY HAVE OR PREVIOUSLY SUFFERED FROM:

HIGH BLOOD PRESSURE …….	YES	NO	WHEN _____
DIABETES ……..	YES	NO	WHEN _____
THYROID CONDITION……...	YES	NO	WHEN _____
SEIZURES ……..…	YES	NO	WHEN _____
LIVER DISEASE ……...	YES	NO	WHEN _____
HEART DISEASE ……..…	YES	NO	WHEN _____
STROKE ……..…	YES	NO	WHEN _____
ARTHRITIS ……	YES	NO	WHEN _____
CANCER ……	YES	NO	WHEN _____
TUBERCULOSIS ……	YES	NO	WHEN _____
PSORIASIS ……..	YES	NO	WHEN _____
POLIO ……	YES	NO	WHEN _____
RHEUMATIC FEVER ……	YES	NO	WHEN _____
HEART ATTACK ……	YES	NO	WHEN _____
ULCER DISEASE ……	YES	NO	WHEN _____
GASTRITIS ……..	YES	NO	WHEN _____
HEPATITIS……	YES	NO	WHEN _____
HIV/AIDS……	YES	NO	WHEN _____
OTHER ……	YES	NO	WHEN _____

LIST ANY SURGERIES:

DATE:	TYPE OF SURGERY:
_____	_____
_____	_____
_____	_____
_____	_____

DATE OF MOST RECENT:

COLONOSCOPY _____ MAMMOGRAM_____

PAP SMEAR _____ MENSTRUAL CYCLE_____

PSA/ PROSTATE EXAM _____

ANY OTHER HOSPITALIZATIONS? YES NO IF YES, LIST DATES AND REASONS:

_____	_____
_____	_____
_____	_____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? YES NO

What medications?	What happened?
_____	_____
_____	_____
_____	_____

ARE YOU TAKING ANY CURRENT MEDICATIONS? YES NO
Please list, including dosage and times per day:

_____

_____

_____

I AUTHORIZE THE REVIEW OF ANY REPORT GENERATED UNDER MY NAME IN THE VA PRESCRIPTION MONITORING PROGRAM. _____ (INITIAL HERE)

WHO IS YOUR CURRENT PRIMARY CARE PHYSICIAN?
Name: _____ Location: _____

FAMILY HISTORY:

Arthritis (RA/OA)	Y/N	HTN	Y/N
Heart Disease	Y/N	Endocrine	Y/N
Muscular Disease	Y/N	Diabetes	Y/N
Cancer	Y/N		

SOCIAL HISTORY: Single/Married/Widow/Separated; Children Y/N and ages _____;

Living Situation _____

Alcohol Use (amount & type) _____; Drug use (amount & type) _____; Tobacco use ____ppd x ____years

Education (years & degrees) _____; Employment (describe) _____

Circle any that apply:

Constitutional Symptoms:

Fever/Chills
Weight Loss
Fatigue

Eyes:

Double Vision
Blurring
Trauma
Glasses/Contacts

ENT & Mouth

Deafness
Sinusitis
Tinnitus
Hoarseness
Vertigo

Cardiovascular:

Chest Pain
Palpitations
HTN
Irregular Beats

Hematologic/Lymphatic:
Bleeding Tendency
Lymph Node Pain/Enlargement
Anemia

Respiratory:

Shortness of Breath
Asthma
COPD
Cough
Coughing up Blood

GI:
Loss of Appetite
Weight Change
Diarrhea
Constipation
Abdominal Pain
Bloody Stools

GU:

Incontinence
Pain with urination
Sexual Dysfunction
Hesitancy

MS:
Fracture
Sprains
Pain
Swelling
Arthritis
Stiffness
Muscle Wasting

Skin/Breast:

Lesions
Scars
Masses

Neuro:

Speech/Swallowing
TIA/CVA
Numbness/Tingling
Seizures
Weakness
Balance/Incoordination
Memory

Psych:

Depression/Anxiety
Hallucinations
Sleep Disturbances

Endocrine:

Increase in thirst/appetite
Hypo/Hyperactivity
Growth/Hair Changes