COLLINS
ORTHOPAEDICS & SPORTS MEDICINE

HEALTH QUESTIONNAIRE **DATE:** _____

Patient name: _____ **DOB:**_____

What are you being seen for today? _____

How did you choose our practice? _____

PAST HISTORY: (Please circle any illnesses you have or have had)

Alzheimer's	Asthma	Chest Pains	Fibrocystic Disorder
Anemia	Bleeding disorder	Degenerative arthritis	Fibromyalgia
Anesthetic Comp.	Blood Clots	Diabetes	Gout
Angina	Blood transfusions	Epilepsy / Seizures	Heart Attack
Arthritis	Chemo/Radiation	Eye / Vision Problems	Heat Disease
Hepatitis	Hypertension	HIV	Lupus
Migraines	MRSA	Osteoarthritis	Osteoporosis
Pace Maker	Psoriatic arthritis	GERD	Rheumatoid Arthritis
Stroke	Thyroid Problems	Tuberculosis	

List any other medical problems you are being treated for:

_____

_____

_____

List any surgeries you have had:

_____

_____

_____

Are you allergic to any medications? **Yes or No**

If yes, which ones? _____

_____

What medications do you take regularly?

_____

_____

_____

FAMILY HISTORY OF DISEASES (Circle any illnesses your family has or has had)

Bleeding Tendency	Diabetes	Osteoarthritis	Rheumatoid Arthritis
Blood Clots	Heart Attack	Stroke	Tuberculosis
Cancer	Heart Disease	Depression	Hyper Tension

Social History

Circle your marital status: Single Married Widowed Divorced

Are you pregnant or think you could be? YES or NO

How many live in your household? _____

Do you consume alcoholic beverages? YES or NO How much? _____

Do you use tobacco products? YES or NO

Do you use recreational drugs? YES or NO

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Please check any symptoms you have now or have had recently:

○None of the above

○Chest pain
○Palpitations
○Light headedness
○Pain in legs
○Color changes in hands or feet
○Non-healing wound or ulcer
○Swelling of hands / Feet

○Shortness of Breath
○Chronic Cough
○Coughing Blood

○Vomiting
○Loss of appetite
○Reflux
○Change in bowel habits
○Abdominal pain

○Muscle weakness
○Fibromyalgia
○Joint pain
○Muscle pain
○Back pain

○Painful urination
○Excessive urination○

○Blood in urine
○Kidney problems
○Urinary Frequency

○Rash
○Psoriasis
○Dry Skin

○Headache
○Sleep Disorder
○Dizziness
○Numbness
○Seizures

○Anxiety
○Depression
○Change in Sleep Pattern
○Panic Attack

○Excessive Thirst
○Cold Intolerance
○Heat Intolerance

○Anemia
○Prior Blood transfusion
○Easy bruising