

STEVEN SAMPSON, D.O.

NON-SURGICAL ORTHOPAEDICS AND SPORTS MEDICINE

HEALTH QUESTIONNAIRE

Name: _____ Today's Date: ____ / ____ / ____ Age: ____

PLEASE FILL OUT THIS FORM AS COMPLETE AS POSSIBLE. IT WILL ASSIST DR. SAMPSON IN DEVELOPING AN INDIVIDUALIZED PLAN OF CARE FOR YOU. THIS INFORMATION IS CONFIDENTIAL.

Medical History: *(Diabetes, high blood pressure, asthma etc)* _____

Surgical History: _____

Current Medications: _____

Allergies: _____

PLEASE PROVIDE A DETAILED DESCRIPTION OF YOUR REASON FOR SEEKING TREATMENT:

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

PLEASE CIRCLE: SUDDEN ONSET GRADUAL ONSET_

PLEASE CIRCLE: IMPROVING PAIN WORSENING PAIN

RATE YOUR AVERAGE DISCOMFORT ON THE SCALE:

0 1 2 3 4 5 6 7 8 9 10
(no pain) (severe pain)

IS YOUR PAIN CONSTANT OR INTERMITTENT? *(circle one)*

HOW WOULD YOU DESCRIBE THE PAIN? Circle one: *sharp dull achy electric:* _____

WHAT MAKES YOUR PAIN WORSE? _____

WHAT HELPS ALLEVIATE YOUR PAIN? _____

DOES THE PAIN RADIATE TO ANY OTHER PART OF YOUR BODY? _____

HAVE YOU SOUGHT PREVIOUS TREATMENT FOR THIS CONDITION?

____ No other treatment ____ Massage therapy ____ Chiropractor
____ Physical therapy ____ Acupuncture ____ Other: _____
____ Epidural Spinal Injection ____ Surgery
____ Medications (Please list) _____

HAVE YOU HAD ANY OF THE FOLLOWING EXAMS RECENTLY? (CIRCLE ALL THAT APPLY)

MRI X-RAY CT SCAN EMG (Nerve test) IF SO, WHEN: _____

Please complete the back of this form.

OCCUPATION: _____

HOBBIES: _____

Height _____ Weight _____

MARITAL STATUS (CIRCLE ONE):

Single Live with Partner Married Separated Divorced Widowed

DO YOU CONSUME ALCOHOLIC BEVERAGES? (CIRCLE ONE)

NEVER RARELY MODERATELY DAILY

DO YOU SMOKE CIGARETTES? YES NO PACKS PER DAY _____ YEARS SMOKED _____

ARE YOU PREGNANT OR TRYING TO BECOME PREGNANT? (CIRCLE ONE) YES NO N/A

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

	YES	NO		YES	NO
General weakness			Abnormal bowel movements		
Leg Cramping			Frequent urination		
Numbness			Unable to urinate		
Shortness of breath			High blood pressure		
Swelling of hands, feet or ankles			Chest pain or angina		
Weakness of muscles or joints			Stroke		
Any difficulty walking			Heart surgery		
Pain in calves or buttocks			Heart disease		
If yes, is that pain relieved by rest?			Cardiovascular disease		
History of falls or poor balance			Epilepsy/Seizures		
Decreased sensation in arms or legs			Kidney disease		
Numbness in arms or legs			Lung disease		
Psychiatric care			Fevers		
Depression			Emphysema/Bronchitis		
Chemical dependency (alcohol/ drugs)			Gout		
Hepatitis			Arthritis		
Weight Loss			Diabetes		
Thyroid problems			Varicose Veins		
Dizziness/Fainting			Irritable Bowel Syndrome		
Cancer			Stomach Ulcer		
Family history of cancer			Disruption in sleeping habits		
Allergies Please specify: _____			Hearing loss		

IS THERE ANY OTHER CONDITION YOU WOULD LIKE TO TELL THE DOCTOR ABOUT?

Please sign below to confirm that the information presented in this questionnaire is accurate:

Signature: _____

Patient Name: _____

Date: _____