



197 E. Franklin Ave
HoHoKus, NJ 07423
Office: (201) 447-0346
Fax: (201) 447-1582

PATIENT & MEDICAL HISTORY QUESTIONNAIRE

Name _____ Referring Physician _____ Date _____

Diagnosis _____

Date of Onset _____ Weight _____ Height _____ Age _____

Is there any history of the following
In your family:

Cancer	Yes	No
High Blood Pressure	Yes	No
Diabetes	Yes	No
Heart Disease	Yes	No
Angina/Chest pain	Yes	No
Stroke	Yes	No
Arthritis	Yes	No
Anemia	Yes	No

Do you have a history of:

Shortness of Breath	Yes	No
Allergies	Yes	No
Asthma	Yes	No
Bronchitis	Yes	No
Polio	Yes	No
Emphysema	Yes	No
Metal Implants	Yes	No
Are you Pregnant	Yes	No

Have you had or do you experience:

Surgery	Yes	No
Nausea/vomiting	Yes	No
Fever/chills/sweats	Yes	No
Unexplained weight change	Yes	No
Numbness or tingling	Yes	No
Muscular weakness	Yes	No
Fainting spells	Yes	No
Dizziness	Yes	No
Night Pain	Yes	No
Bowel or bladder changes	Yes	No
Headaches	Yes	No

Comments/Notes

Date: _____

Describe current history of injury:

Are you taking medications? Yes No _____

Have you had any diagnostic tests (i.e., X-rays, MRI's, Bone scan, EMG, etc.)?
