



Buckeye Health & Rehabilitation
INITIAL HISTORY QUESTIONNAIRE

Name: _____ DOB: _____ Chart/File#: _____

Main Complaint: _____ 2ndary Complaint: _____

How long has the Main Complaint been bothering you: _____ How long has the 2ndary Complaint been bothering you: _____

Have you seen anyone else for the Main complaint (Circle One): Yes No Have you seen anyone else for the 2ndary complaint (Circle One): Yes No

If yes, by whom (List doctors, treatments, & dates): _____ If yes, by whom (List doctors, treatments, & dates): _____

Describe in detail the history of the Main Complaint: _____ Describe in detail the history of the 2ndary Complaint: _____

Are you having other active health issues and what treatments? (Examples: Hypertension - medication, Diabetes - insulin injections, etc.): _____

Do you have inactive health issues, year, & what treatments? (Examples: Gout 2006 - medication, Cancer 2003 - remission/chemo, etc.): _____

Past Injures & Surgeries, Year? (Examples: Broken Leg 2004, Hernia Repair 2005, etc.): _____

Current Medications, Dosage, and Frequency? (Albuteral 200mg - 2x a day, Over the Counter Ibuprofen 400mg - 3 times a day): _____

Allergies (Example: Bees, etc): _____

Family Medical History (Example: Father Diseased - Cancer, Mother Alive - Heart Transplant, Brother Alive - Diabetic): _____

Social History (Example: Social Drinker 2 Beers - 2x a week, Smoker - 2 packs a day, I like to fish, watch movies, play with my 3 children): _____

Occupational History (Example: Hate my job, 6 days/week past 7 years at Caito Foods w/ repetitive motions, lost 4 days of work due to this problem): _____

Other Symptoms: Please list any symptoms you are currently having or had in the past with dates. (Examples of Categories: General, Muscle/Joint/Bone, Genito-Urinary, Gastrointestinal, Cardiovascular, Eye, Ear, Nose, Throat, Skin, Male Symptoms, Female Symptoms):

Other Conditions: Please circle and clarify on the line below any of the following you have had in the past: (Aids, Alcoholism, Anemia, Anorexia, Appendicitis, Arthritis, Bleeding Disorders, Breast Lump, Bronchitis, Bulimia, Cancer, Cataracts, Chemical Dependency, Chicken Pox, Diabetes, Emphysema, Epilepsy, Glaucoma, Goiter, Gonorrhea, Gout, Heart Disease, Hepatitis, Hernia, Herpes, High Cholesterol, HIV Positive, Kidney Disease, Liver Disease, Measles, Migraine Headaches, Miscarriage, Mononucleosis, Multiple Sclerosis, Mumps, Pace Maker, Pneumonia, Polio, Prostate Problems, Psychiatric Care, Rheumatic Fever, Scarlet Fever, Stroke, Suicide Attempt, Thyroid Problems, Tonsillitis, Tuberculosis, Typhoid Fever, Ulcers, Vaginal Infections, Venereal Disease, etc.):

I certify that the above information is correct to the best of my knowledge. I will not hold the doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient's Signature (Guardian's Signature if Minor): _____ Date: _____

Witness' Signature: _____ Date: _____