



Russellville Musculoskeletal Center
15225 Hwy 43 S.; Suite 1
Russellville, AL 35653

MEDICAL QUESTIONNAIRE

Patient Name _____

Family Doctor _____ Referring Doctor _____

Doctor's Address _____

Doctor's Phone Number _____ Your Last Medical Exam _____

Are you taking over the counter or prescription medications? Yes No

Please list current medications with dosage and frequency:

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Please check any of the following and list any other substances that cause allergies or a reaction:

- | | | | | |
|-------------------------------------|-------------------------------------|---------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Ampicillin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Bactrim | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Cortisone | <input type="checkbox"/> Iodine | <input type="checkbox"/> Betadine | <input type="checkbox"/> Latex |

Other: _____

Do you use alternative medicine therapies and/or herbal medicines? If so, please explain: _____

HABITS:

Do you consume alcoholic beverages? Yes No How often do you consume alcohol? _____

Do you use tobacco? Yes No

Smoke _____ Packs per day for _____ months/years Former smoker, last smoke? _____

GENERAL:

Please check any condition that you have previously had or have now:

- | | | | |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Lens Implants | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Deafness | <input type="checkbox"/> Fever | |
| <input type="checkbox"/> Hearing Aids | <input type="checkbox"/> False Teeth | <input type="checkbox"/> Chills | |
| <input type="checkbox"/> Bridge | <input type="checkbox"/> Braces | <input type="checkbox"/> Dizziness | |

MEDICAL HISTORY:

Please check any condition that you have previously had or have now:

HEART

- Coronary artery disease
- Heart Attack
- Murmur/value disorder
- Arrhythmia

LUNG

- Asthma
- Emphysema
- C.O.P.D.
- Pulmonary embolis (P.E.)

ABDOMINAL

- Ulcer / Gastritis
- Hiatal Hernia
- Colitis
- Diverticulitis
- Cholecystitis / Gall Bladder Disorder
- Pancreatitis
- Hepatitis

NEUROLOGICAL

- Stroke
- TIA's
- Epilepsy / Seizures
- Multiple Sclerosis

VASCULAR

- Peripheral Vascular Disease
- Vericose Veins
- Phlebitis
- Deep Vein Thrombosis (DVT)

KIDNEY

- Renal Failure
- Kidney Stones
- Infections (Recurrent)

CANCER

- Lung
- Breast
- Prostate
- Colon
- Skin
- Other _____

OTHER

- High Blood Pressure
- Diabetes
- Rheumatoid Arthritis
- Lupus
- Alcoholism
- Drug Abuse
- Anemia
- Bleeding Disorder
- Depression
- HIV / AIDS
- Gout
- Glaucoma
- Thyroid Disease
- Fibromyalgia
- Other Medial Problems _____

Pregnancy: Are you possibly pregnant now? Yes No

SURGICAL HISTORY

- Total Hip Replacement
- Total Knee Replacement
- Arthroscopy
- Pacemaker
- Spinal Surgery
- Fractures Treated Surgically
- Carpal Tunnel
- Angioplasty
- Coronary Artery Bypass
- Peripheral Vascular Bypass
- Hernia Repair
- Tonsillectomy
- Cholecystectomy
- Appendectomy
- Splenectomy
- Hysterectomy
- Mastectomy
- Breast Biopsy
- Colectomy
- Other Surgeries: (Please list) _____

All of the preceding answers are true and correct to the best of my knowledge, concerning myself or this family member.

| | | | |
|-------------------|------|--------------------|------|
| Patient Signature | Date | Physician Reviewed | Date |
|-------------------|------|--------------------|------|

| | | | |
|-------------------|------|--------------------|------|
| Patient Signature | Date | Physician Reviewed | Date |
|-------------------|------|--------------------|------|