



R. Michael Meneghini, MD

Patient History Questionnaire

Name: _____ DOB: _____ Age: ____ Male Female

Marital Status: Married Single Widowed Divorced

Work History: Working Retired Disabled Other: _____

Occupation: _____

What can we help you with today? Right Left Both Hip Knee

Tell us what you are experiencing: _____

How long has this been going on? _____

Rate your pain on average: (Scale 0-10; 0=No pain, 10= Worst Pain imaginable): _____

Have you had any treatment of this problem before? Yes No

If yes, what treatment(s)? _____

Have you had any surgery for this problem before? Yes No

Type: _____ Date: _____

Type: _____ Date: _____

List all Prescription and Non-Prescription Medications you take See Attached List

Table with 4 columns: Name & Dose (mg), How often, Name & Dose (mg), How often

Allergies: Yes No If yes, please list medication and reaction to it below:

Table with 4 columns: Medication, Reaction, Medication, Reaction

Medical History (Check all medical problems you have been or currently are being treated for):

High Blood Pressure	Stroke	Parkinson's Disease
Heart Disease/Heart Attack	Blood Clots	Multiple Sclerosis
Irregular Heart Rhythm	Diabetes	Seizures/Epilepsy
Peripheral Vascular Disease	Cancer	Nerve Injury
Emphysema/COPD/Asthma	Ulcer	Hepatitis: (circle) A B C
Sleep Apnea	Kidney Disease	Immunodeficiency Disease (HIV)
Tuberculosis (TB)	Thyroid Disease	Degenerative Spine Disease/Sciatica
GERD/Heartburn	Brain Injury	Arthritis/Osteoporosis
Other:		

Surgical History (List all *other* surgeries you have had): **None**

Year	Type of Surgery	Year	Type of Surgery

Did you have any complications during or after any of your surgeries? Yes No
If yes, please select and describe below:

Infection:	Pneumonia:
Bleeding:	Lung Problems:
Blood Clot:	Severe Nausea/Vomiting:
Anesthesia:	Other:

Do you drink alcohol? Yes No If yes: 1-5 6-10 11-15 16-20 >20 drinks/week

Do you currently smoke? Yes No If yes: _____ packs per day for _____ years

Did you ever smoke? Yes No If yes, _____ packs per day for _____ years Year Quit:

History of Substance Abuse? Yes No Which Substance: Last use:

Patient Signature: _____ Date: _____

For office use only:

Vital Signs: Temp: _____ BP: _____ HR: _____ RR: _____

Height: _____ Weight: _____ BMI: _____

PA/RN/MA Signature: _____ Date/Time: _____

MD Signature: _____ Date/Time: _____