

JAMES R. MC CLURG, M.D., APC
PRIVATE PATIENT QUESTIONNAIRE

Patient Name: _____ Today's date: _____

DOB: _____ AGE: _____ Right Handed Left Handed Ambidextrous

Who referred you to this office? _____

Has another doctor advised you to seek care for this condition? Yes No

Name of referring physician: _____

Please list any current medications: _____

List any allergies to foods or medications: _____

Please list any operations (and dates) you have ever had: _____

Have you been hospitalized within the last 10 years? Yes No Why? _____

Past Medical History: Please check the "yes" or "no" box to indicate if **you** have any of the following illnesses.

	Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Clotting problem	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Kidney failure	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
Lung clots	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>

Explain: _____

Family History: Please Check the “yes” or “no” box to indicate whether **any relatives** have any of the following illnesses. If yes, please indicate which relative(s) have the problem.

	Yes	No	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excessive bleeding	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anesthesia problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Birth defects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____

Social History:

Place of birth? _____

Primary language? _____

Education completed? _____

What is your occupation? _____

Work status: Working Retired Disabled Student Unemployed Homemaker

Other: _____

Marital status: Single Married Separated Divorced Widowed other: _____

Number of children: _____ Ages: _____

	Yes	No		
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	How much? _____	How long? _____
Do you drink?	<input type="checkbox"/>	<input type="checkbox"/>	How much? _____	How often? _____
Sports or exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Explain: _____	

Review of Systems:

Please check the “Yes” or “No” box to indicate if you are experiencing any of the following symptoms:

		Yes	No		Yes	No
GENERAL:	Fevers	<input type="checkbox"/>	<input type="checkbox"/>	Chills	<input type="checkbox"/>	<input type="checkbox"/>
	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>			
ENT:	Ringing of ears	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
	Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>
EYES:	Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	Eye itching	<input type="checkbox"/>	<input type="checkbox"/>
LUNGS:	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Coughing blood	<input type="checkbox"/>	<input type="checkbox"/>
	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Frequent cough	<input type="checkbox"/>	<input type="checkbox"/>
CARDIAC:	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Wake short of breath	<input type="checkbox"/>	<input type="checkbox"/>
	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Leg swelling	<input type="checkbox"/>	<input type="checkbox"/>
	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
GASTRO:	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Trouble swallowing	<input type="checkbox"/>	<input type="checkbox"/>
	Vomiting blood	<input type="checkbox"/>	<input type="checkbox"/>	Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Black or tarry stools	<input type="checkbox"/>	<input type="checkbox"/>
SKIN:	Skin ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>
	Redness	<input type="checkbox"/>	<input type="checkbox"/>	Boils	<input type="checkbox"/>	<input type="checkbox"/>
NEURO:	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Balance problems	<input type="checkbox"/>	<input type="checkbox"/>
	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Loss of coordination	<input type="checkbox"/>	<input type="checkbox"/>
	Tremors/shaking	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss	<input type="checkbox"/>	<input type="checkbox"/>
GU:	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	<input type="checkbox"/>
	Dribbling	<input type="checkbox"/>	<input type="checkbox"/>	Delayed urination	<input type="checkbox"/>	<input type="checkbox"/>
	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Urinating at night	<input type="checkbox"/>	<input type="checkbox"/>
	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>			
ENDO:	Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>
	Tired /sluggish	<input type="checkbox"/>	<input type="checkbox"/>	Too cold or too hot	<input type="checkbox"/>	<input type="checkbox"/>
	Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss	<input type="checkbox"/>	<input type="checkbox"/>
HEMA:	Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
	Swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	Blood clotting prob.	<input type="checkbox"/>	<input type="checkbox"/>
PSYCH:	Depression	<input type="checkbox"/>	<input type="checkbox"/>	High stress levels	<input type="checkbox"/>	<input type="checkbox"/>
	Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
	Suicidal ideations	<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>
ALLERGY:	Jewelry stains	<input type="checkbox"/>	<input type="checkbox"/>	Metal intolerance	<input type="checkbox"/>	<input type="checkbox"/>

HISTORY OF INJURY OR ILLNESS

1. What problems are you here for today? _____
2. What is the main reason you are seeking care for today? _____
3. For how long have you had this problem? _____
4. Have you had similar symptoms in the past? Yes _____ No _____
5. What was the date of the injury / onset of symptoms? _____ Hour _____ AM/PM
6. If there is no specific date of injury, when did you first begin to have problems? _____
7. How did the injury occur? _____

8. What part(s) of your body were injured? _____
9. Where did you first seek care for this condition? _____
10. When did you first see a doctor? _____
11. Did you go to the emergency room or urgent care? Yes No Facility: _____
12. What care was provided at the ER or Urgent Care? _____

13. Were you hospitalized at any time as a consequence of the injuries you sustained from the accident?
 Yes No Name of hospital/city/state: _____
Date admitted: _____ Date discharged: _____
Treating physician: _____
What was done for you at the hospital? _____
14. Have you been seen at a Clinic or doctor's office for this condition? Yes No
15. Where and when were you seen? _____
16. What were you told was wrong? _____
17. What treatment has been provided for this condition? Check all that apply:
 Medications Injections Therapy Braces/splints Exercise program
 Casting Crutches Surgery Acupuncture Other: _____
18. Have any of the following tests been performed for this condition? Check all that apply:
 X-rays MRI Bone Scan Indium Scan Blood test
 CT Scan EMG Ultrasound Arthrogram
 Other: _____
19. Have you consulted with any other doctors for this condition? (Write in the back of the page is necessary)
Dr: _____ Specialty: _____ Date seen: _____
Treatment provided: _____

20. Do you have any pain? Yes No Where is it? _____

21. What does it feel like? (Sharp, dull, burning, pins, needles, stabbing, etc.) _____

22. How often do you experience pain?

Less than 1/4 of the day 1/4 of the day 1/2 of the day 3/4 of the day All day

23. What is the best description of the severity of your pain?

Mild Mild to moderate Moderate Moderate to severe Severe

24. Does your pain travel to other body parts? Yes No Where? _____

25. What activities cause you to have pain?

Coughing Sneezing Sitting Turning neck
 Standing Bending Stooping Twisting Walking Stairs Uneven terrain
 Kneeling Squatting Pivoting Inclines Running Jumping Working out
 Sports Footwear Lifting Pushing Pulling Gripping Grasping
 Torquing Reaching Throwing Driving Cold Vibration Keyboarding
 Other: _____

26. What relieves your pain?

Resting Icing Heat Creams Medications
 Stretching Massage Bracing Splinting Therapy Acupuncture
 Other: _____

27. What activities are you unable to perform because of this injury? _____

28. Do you have any hand numbness or tingling at night? Yes No

29. Which fingers normally tingle or go numb? _____

30. Does pain wake you up? Yes No How often? _____

31. Is there any stiffness? Yes No Where? _____

32. Is there any weakness? Yes No Where? _____

33. Is there any numbness? Yes No Where? _____

34. Is there any tingling? Yes No Where? _____

35. Any locking in joints? Yes No Where? _____

36. Any popping of joints? Yes No Where? _____

37. Any giving way of joints? Yes No Where? _____

38. Any grinding of joints? Yes No Where? _____

39. Is there any swelling of joints? Yes No Where? _____

40. Any deformity of joints? Yes No Where? _____

41. Any instability of joints? Yes No Where? _____

Patient's signature: _____ Date: _____

Authorizing signature: _____ Relationship: _____