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Dr. Nick Copeli

Medical History Questionnaire

Patient Name: _____

Date of Birth: _____

Date: _____

1. Reason for Visit

What problem or injury brings you in today?

When did the symptoms begin?

Have you had this problem before?

- Yes
 No

If yes, please explain:

2. Pain Assessment

Where is your pain or injury located?

On a scale from 0–10, how severe is your pain?

0 (No pain) — 10 (Worst pain imaginable)

Pain Level: _____

What activities make the pain worse?

What helps relieve the pain?

3. Physical Activity

Do you participate in sports or regular physical activity?

- Yes
 No

If yes, which sport or activity?

How many days per week do you exercise?

Have you had any previous sports injuries?

- Yes
 No

If yes, please describe:



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4. Past Medical History

Have you ever been diagnosed with any of the following?

- High Blood Pressure
- Diabetes
- Heart Disease
- Asthma
- Arthritis
- Thyroid Disease
- Neurological Disorders
- Other Medical Conditions

If yes, please explain:

5. Surgical History

Have you had any surgeries?

- Yes
- No

If yes, please list procedure and approximate date:

6. Current Medications

Please list all medications, supplements, or vitamins you currently take:

7. Allergies

Do you have any allergies to medications, food, or materials?

- No
- Yes

If yes, please list:

8. Lifestyle Factors

Do you smoke or use tobacco products?

- Never
- Former smoker
- Current smoker

Do you drink alcohol?

- No
- Occasionally
- Regularly



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9. Family Medical History

Do any close family members have a history of:

- Heart Disease
- Diabetes
- Arthritis
- Cancer
- Other Significant Medical Conditions

If yes, please explain:

10. Additional Information

Is there anything else about your health that the doctor should know?

Patient Acknowledgment

I certify that the information provided is accurate and complete to the best of my knowledge.

Patient Signature: _____

Date: _____