

HEALTH HISTORY

Please answer the questions below concerning your health history. Be sure to list all conditions or symptoms, both past and present. **Circle** the condition if it is listed or write it in the spaces provided if it is not listed.

- **An understanding of your health history will help us to determine appropriate diagnosis and care.**

Full Name: _____ **Date:** _____

Age: _____ **Gender:** M / F **Height:** _____ **Weight:** _____

Review of Systems:

Do you have skin, hair or nail problems? _____ YES NO

Do you have mouth and/or throat problems? *bleeding gums, difficulty swallowing, cancer*
_____ YES NO

Do you have nose and/or sinus problems? _____ YES NO

Do you have ear problems? *ringing, loss of hearing (right / left)* _____ YES NO

Do you have chest or lung (breathing) problems? *chest pain, broken ribs, asthma* _____ YES NO

Have you been diagnosed with lung cancer? _____ YES NO

Do you smoke? How many per day? _____ How many years? _____ YES NO

Do you have heart and / or blood vessel problems? *high blood pressure, (medication: _____)* YES NO

History of stroke, hardening of the arteries, fainting / drop attacks, carotid artery surgery _____ YES NO

Do you have blood or lymph problems? *bleeding disorders, taking blood thinning medications (Coumadin, Plavix, Warfarin) Other: _____* YES NO

Do you have digestive problems? *GERD / acid reflux (medications: _____)* YES NO

Loss of bowel control, blood in stool, hemorrhoids, Other: _____ YES NO

Do you have genital problems? (*prostate, testicular, vaginal, ovarian*) _____ YES NO

Do you have urinary (including kidney or bladder) problems? *Difficulty / painful urination, loss of bladder control, blood in urine* _____ YES NO

Do you have nervous system diseases and / or mental health problems? _____ YES NO

Do you take medication(s) for this? Yes / No Which one(s)? _____ YES NO

Do you have gland and / or hormone problems? _____ YES NO

Do you take medication(s) for this? Which one(s)? _____ YES NO

Replacement Therapy? _____ YES NO

Do you have allergy or immunity problems? _____ YES NO

Do you have muscle, tendon or ligament problems? _____ YES NO

Do you have bone disease? *Osteoporosis, Pagets, Cancer* _____ YES NO

Do you have any joint diseases? *Rheumatoid / osteoarthritis, gout* _____ YES NO

Have you had joint replacement? Which one/side? _____ YES NO

Have you been diagnosed with herniated/slipped disc? _____ YES NO

Have you had disc or spine surgery? What area of the spine and when? _____ YES NO

Have you ever experienced partial or complete paralysis of any area of your body? _____ YES NO

HEALTH HISTORY

Name: _____

Date: _____

Females:

Do you have menstrual problems? _____ YES NO

Have you ever taken birth control? *How many combined years?* _____ YES NO

Is there any chance you are currently pregnant? _____ YES NO

Do you have breast problems or cancer? _____ YES NO

Breast Removal? Right / Left / Both _____ YES NO

How long ago was your last breast exam? _____ YES NO

Past History:

1. Tell us if you have ever been diagnosed as having a particular condition such as diabetes, cancer, AIDS, etc.: _____

a. What treatment(s) are you receiving? _____

2. Please describe any physical injuries you have experienced (such as falls automobile accidents, whiplash, concussion, head injury, lacerations, sprains, strains, dislocations, broken or fractured bones): _____

3. List any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth): _____

4. Please list any hospitalizations (other than listed above): _____

5. **Medications:** Please list all medications (prescription & non-prescription) you are currently taking or take on an occasional basis you have not already listed in this paper: _____

6. Please list any vitamins or supplements you are currently taking or take on an occasional basis: _____

7. Is your diet: Balanced Fair Poor Excessive Restricted

8. How often do you eat: a) Fruits & Vegetables: _____ servings per week

b) Fast Food: _____ servings per week

Family History:

9. List any diseases or conditions that are common among your family members (i.e. inherited diseases or conditions): *rheumatoid arthritis, gout, osteoporosis, scoliosis, migraines, stroke, diabetes, heart conditions, cancer, tumors, back / neck problems:* _____

HEALTH HISTORY

Name: _____

Date: _____

Social History:

- 10. In what position do you usually sleep? _____
- 11. How many hours per night do you sleep? _____ Hours. Is this normal or a recent change? _____
- 12. How many hours per day and days per week do you exercise? _____ hours a day, _____ days per week.
- 13. How do you spend your spare time (hobbies, etc.)? _____
- 14. Do you use: Caffeine _____ per day Alcohol _____ per week Recreational Drugs
- 15. Please describe your work:
 - a. Type: _____
 - b. Typical body position: Standing Sitting Climbing Working Overhead
 - c. Physical Demands: High Moderate Mild Sedentary
 - d. Stress Level: High Medium Low

Additional Questions: Have you experienced any of the following within the **past three months?**

- Change in headaches (worst headache you've ever had)? _____ YES NO
- Are you losing weight without trying? _____ YES NO
- Pain that wakes you at night? _____ YES NO
- Have you had a change in bowel or bladder habits? _____ YES NO
- Have you had a sore that doesn't heal? How long? _____ YES NO
- Have you recently had any unusual bleeding or discharge? _____ YES NO
- Do you have a thickening / lump in the breast or anywhere else? _____ YES NO
- Do you have indigestion or difficulty swallowing? _____ YES NO
- Have you had an obvious change in a wart or mole? _____ YES NO
- Do you have a nagging cough or hoarseness? How Long? _____ YES NO

16. In the following space please describe any other information we should know not already mentioned: _____

17. Who is your medical doctor? _____

In the past 14 days, have you experienced any of the following?		
<input type="checkbox"/> Yes <input type="checkbox"/> No Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No Head Trauma	<input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty Walking
<input type="checkbox"/> Yes <input type="checkbox"/> No Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No Memory Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No Numbness / Tingling
<input type="checkbox"/> Yes <input type="checkbox"/> No Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No Incoordination	<input type="checkbox"/> Yes <input type="checkbox"/> No Pressure in arms / legs
<input type="checkbox"/> Yes <input type="checkbox"/> No Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No Speech Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No Double / Blurred Vision
<input type="checkbox"/> Yes <input type="checkbox"/> No Stomach Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No Vertigo (Spinning)	<input type="checkbox"/> Yes <input type="checkbox"/> No Tinnitus (Ringing in Ears)
<input type="checkbox"/> Yes <input type="checkbox"/> No Minor Fall	<input type="checkbox"/> Yes <input type="checkbox"/> No Personality Change	<input type="checkbox"/> Yes <input type="checkbox"/> No Loss of strength (grip or dragging feet)
<input type="checkbox"/> Yes <input type="checkbox"/> No Major Fall	<input type="checkbox"/> Yes <input type="checkbox"/> No New type of headache	

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