

HEALTH HISTORY

Name: _____ DOB: _____ Today's Date: _____

What is the reason for your visit? _____ Referring Physician: _____

SYMPTOMS Check symptoms you currently have or have had in the past year

GENERAL

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

MUSCULOSKELETAL

- Muscle cramps
- Stiff joints
- Swelling of joints
- Generalized arthritis
- Rheumatoid arthritis
- Fibromyalgia syndrome
- Osteoporosis
- Neck pain
- Upper back pain
- Low back pain
- Difficulty with walking
- Pain in feet
- Cold upper extremities

HEPATIC

- Liver disease
- Hepatitis
- Jaundice
- Gallbladder problems

GASTROINTESTINAL

- Poor Appetite
- Bloating
- Bowel Changes
- Constipation
- Diarrhea
- Excessive hunger
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

CARDIOVASCULAR

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Rapid heart rate
- Swelling of ankles
- Heart attack
- Bypass surgery
- Angioplasty
- Mitral valve prolapse
- Heart murmur
- Heart failure
- Shortness of breath with walking

ENDOCRINE

- Excessive thirst or urination
- Heat intolerance
- Cold intolerance
- Thyroid problems
- Diabetes Mellitus

EYE, EAR NOSE, THROAT

- Bleeding Gums
- Blurred Vision
- Crossed eyes
- Difficulty Swallowing
- Double Vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Ringing in ears
- Sinus problems
- Vision—Flashes
- Vision—Halos

URINARY

- Frequent urination
- Difficulty with urination
- Burning
- Lack of bladder control
- Blood in urine
- Kidney stones

HEMATOLOGIC

- Swollen glands
- Anemia
- Easy bleeding
- Slow to heal
- Enlarged glands
- Phlebitis
- HIV positive
- On blood thinners

RESPIRATORY

- Recurrent Cough
- Chronic Bronchitis
- Emphysema
- COPD
- Bronchial asthma
- Tuberculosis
- Wheezing

PERIPHERAL VASCULAR

- Poor circulation in arm
- Blood clots in arm
- Varicose veins
- Poor circulation in legs
- Blood clots in legs
- Vascular surgery

SKIN

- Bruise easily
- Hives
- Itching
- Changes in skin color
- Changes in hair or nails
- Recurrent rashes

MEN only

- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis

WOMEN only

- Abnormal Pap Smear
- Breast lump
- Extreme menstrual pain
- Painful intercourse

CONDITIONS Check conditions you have or have had in the past

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Miscarriages | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Polio | <input type="checkbox"/> Ulcers |

MEDICATIONS List medications you are currently taking

ALLERGIES:

HEALTH HISTORY

PREVIOUS SURGERIES (include year and doctors name)

SERIOUS ILLNESS/INJURIES

HABITS

SMOKING: Have you ever smoke? Yes No Do you smoke now? Yes No Smoking since? _____
How many cigarettes per day? _____ Cigars per day? _____ Pipe? _____

ALCOHOL: Do you drink alcohol? Yes No If yes, How much? _____
Have you ever had a problem with alcohol? Yes No If yes, explain _____

CAFFEINE: Do you consume drinks with caffeine? Yes No If yes, Coffee Tea Iced Tea Colas Other
Number of cups per day _____

DRUGS: Do you use any street drugs? Yes No If yes, explain _____
Have you ever had a problem with recreational drugs? Yes No If yes, explain _____

PAIN HISTORY

Where is your pain? (be specific) _____

What does you pain feel like? _____

What makes it feel better? _____

What makes it feel worse? _____

PAST PAIN HISTORY Check all treatments you have had

<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Chiropractic Treatment	<input type="checkbox"/> Electrical Stimulation	<input type="checkbox"/> Massage
<input type="checkbox"/> Epidurals	<input type="checkbox"/> Nerve blocks	<input type="checkbox"/> Radiofrequency Ablation	<input type="checkbox"/> Heat/Ice
<input type="checkbox"/> Trigger Point Injections	<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Aqua Therapy	<input type="checkbox"/> Psychotherapy

INTERVENTIONAL PROCEDURES you have had for pain (include date and doctor)

TESTING Include dates and facility where performed

X-rays _____

CT Scan _____

Myelogram _____

MRI Scan _____

Discogram _____

Bone Scan _____

Nerve Conduction _____

Other _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____

Date _____

Reviewed By _____

Date _____