PATIENT HEALTH HISTORY FORM

Name: _____ Date of Birth: _____ Today's Date: _____

CURRENT HEALTH HISTORY:

Do you have a primary health care provider? ❑ Yes ❑ No Provider's name: _____

When did you last receive health care and from whom? _____

For what reason? _____

Primary health concern today (reason for your visit): _____

_____

Is the above related to a work injury or car accident? ❑ Yes ❑ No Date injury occurred: _____

Has your case been referred to an attorney? ❑ Yes ❑ No

How does this condition affect you? Does it interfere with your daily activities (physical activity, work, sleep, sex, ability to care for self or family)? _____

_____

Does anyone else in your family have this condition? ❑ Yes ❑ No Their relationship to you: _____

What other treatment(s) have you had for this condition? _____

_____

Do you have additional health concerns at this time? If yes, please list in order of importance: _____

_____

Do you currently have any infectious diseases? ❑ Yes ❑ No Please describe: _____

Do you currently suffer from any chronic illnesses? ❑ Yes ❑ No Please describe: _____

_____

Please list ALL prescription medications, non-prescription medications, vitamins, supplements, herbs or other remedies you currently take: _____

_____

Please list any foods, medications, plants, chemicals or other substances you are allergic or hypersensitive to (also describe the type of reaction you have to them): _____

_____

FAMILY MEDICAL HISTORY:

	Mother	Father	Brother(s)	Sister(s)	Spouse	Children
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=good, P=poor)	_____	_____	_____	_____	_____	_____
Age at death (if deceased)	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____

FAMILY MEDICAL HISTORY: (cont.)

Please check any of the following that members of your family have had:

	Mother	Father	Brother(s)	Sister(s)	Spouse	Children
Heart disease	_____	_____	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Mental illness	_____	_____	_____	_____	_____	_____

PAST HEALTH HISTORY:

Immunizations: (Please circle any of the following immunization you have had)

Measles/Mumps/Rubella Diphtheria Pertussis Tetanus Polio

Other: _____

Childhood Illnesses: (Please circle any of the following diseases you have had)

Measles Mumps Rubella Diphtheria Pertussis Chicken pox Rheumatic fever Scarlet fever

Have you ever had any severe illnesses or injuries or experienced any major traumas? (Describe) _____

_____

_____

Hospitalizations and Surgeries: (Please continue on the back of this page if you need more space)

Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

X-rays/CAT scans/MRI's/NMR's/Special Studies: (Please continue on the back if you need more space)

Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

Please check any of the following diseases or conditions that you either have now or have had in the past:

- ❑ Heart disease/heart attack
- ❑ Cancer
- ❑ Stroke
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Diabetes
- ❑ Anemia
- ❑ Hemophilia/bleeding disorder
- ❑ Hepatitis B or C
- ❑ HIV/AIDS
- ❑ Tuberculosis
- ❑ Seizures/epilepsy
- ❑ Frequent headache/migraine
- ❑ Multiple sclerosis
- ❑ Glaucoma
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Pneumonia
- ❑ Pleurisy
- ❑ Liver disease
- ❑ Gallbladder disease
- ❑ Kidney disease/kidney stones
- ❑ Stomach ulcers
- ❑ Colitis/inflammatory bowel disease
- ❑ Malaria
- ❑ Rheumatic fever
- ❑ Arthritis
- ❑ Lupus
- ❑ Mononucleosis
- ❑ Sexually transmitted disease
- ❑ Alcoholism/substance abuse
- ❑ Mental illness

Please check any condition you've either had in the past or have currently:

Musculoskeletal:

	Past	Present
Neck pain	❑	❑
Shoulder pain	❑	❑
Upper back pain	❑	❑
Lower back pain	❑	❑
Arm pain	❑	❑
Wrist or hand pain	❑	❑
Leg pain	❑	❑
Ankle or foot pain	❑	❑
Jaw pain/clicking	❑	❑
Joint pain/stiffness	❑	❑
Muscle spasms/cramps	❑	❑

Neurological:

	Past	Present
Dizziness	❑	❑
Numbness/tingling/burning	❑	❑
Paralysis	❑	❑
Loss of Balance	❑	❑
Fainting	❑	❑
Seizures/epilepsy	❑	❑

Endocrine:

	Past	Present
Hypothyroidism	❑	❑
Hyperthyroidism	❑	❑
Hypoglycemia	❑	❑
Feeling hot or cold	❑	❑
Other endocrine disorder:		
Specify: _____	❑	❑

Mental/Emotional:

	Past	Present
Nervousness/Anxiety	❑	❑
Depression	❑	❑
Mood swings	❑	❑
Difficulty concentrating	❑	❑
Memory problems	❑	❑
Insomnia	❑	❑

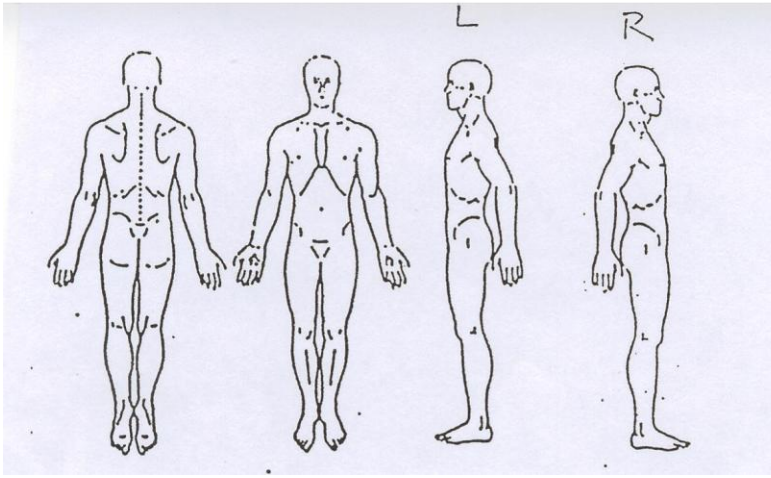
Energy and Immunity:

	Past	Present
Fatigue	❑	❑
Frequent colds/infections	❑	❑
Slow wound healing	❑	❑

Respiratory:

	Past	Present
Persistent cough	❑	❑
Wheezing/difficulty breathing	❑	❑
Shortness of breath	❑	❑

Please indicate where you are currently experiencing symptoms on the figures below:



Skin:

	Past	Present
Dry skin	❑	❑
Itchy skin	❑	❑
Rash/Redness	❑	❑
Hives	❑	❑
Eczema	❑	❑
Psoriasis	❑	❑

Eye/Ear/Nose/Throat:

	Past	Present
Eye pain/strain	❑	❑
Dry, red, itchy, or tearing eyes	❑	❑
Impaired vision/blindness	❑	❑
Impaired hearing/deafness	❑	❑
Ringing in the ears	❑	❑
Ear ache	❑	❑
Sinus/nasal congestion	❑	❑
Allergies/hay fever	❑	❑
Frequent bloody nose	❑	❑
Frequent sore throat	❑	❑
Difficulty swallowing	❑	❑
Frequent hoarse voice	❑	❑

Cardiovascular:

	Past	Present
Chest pain	❑	❑
Irregular heartbeat	❑	❑
Heart pounding or fluttering	❑	❑
Swelling of the ankles	❑	❑
Varicose veins	❑	❑
Poor circulation	❑	❑

Gastrointestinal:

	Past	Present
Excessive hunger or thirst	❑	❑
Nausea/vomiting	❑	❑

Gastrointestinal (cont.)

	Past	Present
Gas/bloating	❑	❑
Frequent belching	❑	❑
Heartburn/acid reflux	❑	❑
Abdominal pain or cramping	❑	❑
Constipation	❑	❑
Diarrhea	❑	❑
Bloody or black, tarry stool	❑	❑
Mucous or food in the stool	❑	❑
Hemorrhoids	❑	❑

Urinary:

	Past	Present
Impaired urination	❑	❑
Painful urination	❑	❑
Frequent urination	❑	❑
Incontinence	❑	❑
Blood in the urine	❑	❑
Frequent urinary tract infection	❑	❑

Male Reproductive:

	Past	Present
Prostate problems	❑	❑
Testicular pain/swelling	❑	❑
Erectile dysfunction	❑	❑
Penile discharge	❑	❑

Female Reproductive:

	Past	Present
Premenstrual problems	❑	❑
Irregular menstruation	❑	❑
Painful menstruation	❑	❑
Heavy bleeding	❑	❑
Bleeding between periods	❑	❑
Difficulty conceiving	❑	❑
Unusual vaginal discharges	❑	❑
Breast lumps	❑	❑
Breast tenderness	❑	❑
Nipple discharge	❑	❑
Menopausal symptoms	❑	❑

MENSTRUAL/BIRTHING HISTORY:

Age at first menses: _____ Are you peri/postmenopausal? _____ Date last period started: _____

# of pregnancies: _____ # of live births: _____ # of miscarriages: _____ # of abortions: _____

Are you currently sexually active? ❑ Yes ❑ No If yes, do you currently use birth control? ❑ Yes ❑ No

Current method of birth control: _____ Other methods used in the past: _____

Do you have any reason to believe that you might be pregnant at this time? ❑ Yes ❑ No

Date of most recent PAP smear: _____ Any abnormalities? ❑ Yes ❑ No

Date of most recent mammogram: _____ Any abnormalities? ❑ Yes ❑ No

LIFESTYLE:

Occupation: _____ Do you enjoy your work? Why/why not?

_____

What kinds of foods do you eat in a typical day:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you drink alcohol or coffee/caffeinated sodas? How much per day/week? _____

How much water do you drink per day? _____

Do you smoke? ❑ Yes ❑ No # years smoking: _____ # cigarettes/packs per day: _____

Do you exercise regularly? ❑ Yes ❑ No What kind of exercise do you do, how often do you do it and for how long each session?_____

How many hours of sleep do you usually get per night? _____