PATIENT HEALTH HISTORY FORM (Page 1)

Patient Name:______________________________________ DOB:__________ Age:____ Sex:____ Date:__________

Current Health History

Reason for your visit today: ____

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

How does this condition affect you? Does it interfere with: ❑ your ability to work ❑ physical activity ❑ sleep ❑ ability to care for yourself/family ❑ ability to do household chores ❑ other: ____________

Do any family members have this condition? ❑Yes ❑No Relationship to you: ____________

Treatment(s) you've had for this condition: ____________

Additional health concerns you have (list in order of importance): ____________

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

Primary care provider (name/location): ____________

Specialists you currently see (name/specialty): ____________

Current Medications (prescription AND non-prescription)

Medication Name	Dosage	Reason taken	Medication Name	Dosage	Reason taken

Vitamins, Supplements, Herbs (list all that you currently take)

Allergies/Hypersensitivities

(List foods, medications, plants, and any other substances you are allergic/sensitive to and describe your reaction to them)

Family Medical History (check/complete any that apply)

	Mother	Father	Sisters	Brothers	Children
Age (if living)					
Age at death					
Cause of death					
Heart disease					
High blood pressure					
Diabetes (Type I or II)					
High cholesterol					
Cancer (list type)					
Stroke					
Substance abuse					
Mental health issues					

Surgeries/Hospitalizations

Date	Type of Surgery/Reason in Hospital	Date	Type of Surgery/Reason in Hospital

XRays, CT Scans, MRIs, any other special imaging you've had

Date	Type of Imaging/Reason it was done	Date	Type of Imaging/Reason it was done

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PATIENT HEALTH HISTORY FORM (Page 2)

Patient Name:____ DOB:__________ Age:____ Sex:____ Date:__________

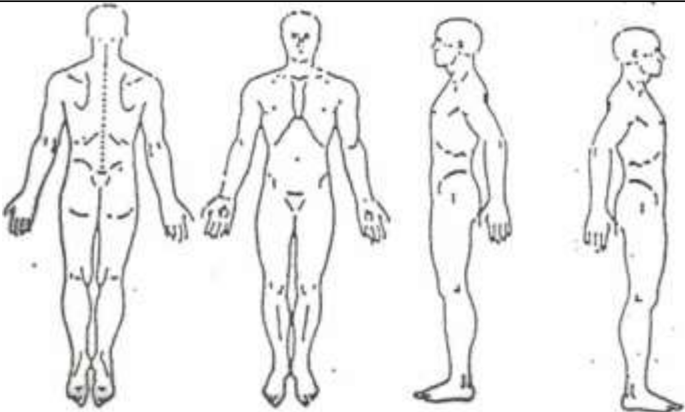
Personal Medical History (check any you have currently or have had in the past)

Condition	Now	Past	Condition	Now	Past	Condition	Now	Past
Addiction:________________			Epilepsy			Migraines		
Anemia			Fainting			Mononucleosis		
Anxiety			Fibromyalgia			Multiple sclerosis		
Arthritis: osteo or rheumatoid			Gallbladder disease/stones			Neurological disease		
Asthma			Heart disease/heart attack			Numbness/tingling		
Autoimmune disease			Hepatitis: A B C			Osteoporosis		
Blood clots			Herpes: oral genital			Pacemaker		
Bronchitis			High blood pressure			Paralysis		
Bruise or bleed easily			High cholesterol			Pneumonia		
Cancer (type_____________)			HIV/AIDS			Rash:___________________		
Celiac disease			Hyperthyroid (high)			Seizures		
Chronic fatigue syndrome			Hypothyroid (low)			Sexually transmitted disease		
COPD			Irritable bowel syndrome			Sleep apnea		
Crohn's disease			Inflammatory bowel disease			Slow wound healing		
Depression			Kidney disease/stones			Stomach ulcers		
Diabetes			Liver disease/cirrhosis			Tuberculosis		
Difficulty concentrating			Loss of balance			Ulcerative colitis		
Dizziness			Memory problems			Varicose veins		
Emphysema			Mental illness: ___________			Vertigo		

Other serious illness, injury or trauma you have now or in the past:

Body Pain

Shade in or mark your area(s) of pain:



Check all that apply

- ❑ Headache/migraine
- ❑ Sinus pain
- ❑ Eye pain
- ❑ Ear pain
- ❑ Jaw pain/TMJ
- ❑ Tooth pain
- ❑ Neck pain
- ❑ Shoulder pain
- ❑ Upper arm pain
- ❑ Elbow pain
- ❑ Forearm pain
- ❑ Wrist pain
- ❑ Hand pain
- ❑ Finger pain
- ❑ Chest pain
- ❑ Rib pain
- ❑ Upper abdominal pain
- ❑ Lower abdominal pain
- ❑ Pelvic pain
- ❑ Upper back pain
- ❑ Lower back pain
- ❑ Buttock pain
- ❑ Hip pain
- ❑ Thigh pain
- ❑ Knee pain
- ❑ Lower leg pain
- ❑ Ankle pain
- ❑ Foot pain
- ❑ Toe pain
- ❑ Muscle spasms/cramping

Lifestyle

Occupation: ____ Do you enjoy your work? ❑Yes ❑No

Why/why not? ____

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

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Do you drink alcohol? ❑Yes ❑No How much per day/week?______________________________

caffeinated drinks? ❑Yes ❑No 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? ___________________________