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**

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 have heart and / or blood vessel problems? *high blood pressure*_____ □ 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* _____ □ 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

_____ □ YES □ NO

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

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

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

Replacement Therapy? _____ □ 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. 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 ☐ 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 _____ ☐ YES ☐ NO

Would you consider this the worst Headache you have 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?		
☐ Yes ☐ No Nausea	☐ Yes ☐ No Head Trauma	☐ Yes ☐ No Difficulty Walking
☐ Yes ☐ No Vomiting	☐ Yes ☐ No Memory Loss	☐ Yes ☐ No Numbness / Tingling
☐ Yes ☐ No Fever	☐ Yes ☐ No Incoordination	☐ Yes ☐ No Pressure in arms / legs
☐ Yes ☐ No Diarrhea	☐ Yes ☐ No Speech Problems	☐ Yes ☐ No Double / Blurred Vision
☐ Yes ☐ No Stomach Pain	☐ Yes ☐ No Vertigo (Spinning)	☐ Yes ☐ No Tinnitus (Ringing in Ears)
☐ Yes ☐ No Minor Fall	☐ Yes ☐ No Personality Change	☐ Yes ☐ No Loss of strength (grip or dragging feet)
☐ Yes ☐ No Major Fall	☐ Yes ☐ No New type of headache	