Health History

ALL INFORMATION IS CONFIDENTIAL

Patient Name _____ **Date** _____

Circle "C" for Current problems or Mark the box with a check ☑ next to the conditions you've had in the past

General Health Conditions:

C ☐ Alcoholism C ☐ Allergies C ☐ Anemia C ☐ Anxiety C ☐ Bi-polar disorder C ☐ Cancer C ☐ Chicken pox
C ☐ Cold sores C ☐ Depression C ☐ Diabetes C ☐ Dizziness C ☐ Edema (Swelling) C ☐ Endometriosis C ☐ Epilepsy
C ☐ Fainting C ☐ Fatigue C ☐ Goiter C ☐ Headaches C ☐ Hepititis C ☐ Herpes C ☐ High cholesterol
C ☐ HIV/ AIDS C ☐ Malaria infection C ☐ Measles C ☐ Miscarrage C ☐ Multiple sclerosis C ☐ Mumps C ☐ Nervousness
C ☐ Osteoporosis C ☐ Pace maker C ☐ Polio C ☐ Rhumatic fever C ☐ Stroke C ☐ Tremors C ☐ Thyroid disease
C ☐ Tuberculosis C ☐ Unexplained weight loss C ☐ Unexplained weight gain

Muscle & Joint Conditions:

C ☐ Arthritis (Joint pain) C ☐ General muscle pain C ☐ Neck pain C ☐ Mid-back pain C ☐ Low-back pain C ☐ Shoulder pain C ☐ Elbow pain
C ☐ Wrist/Hand pain C ☐ Hip pain C ☐ Knee pain C ☐ Ankle pain C ☐ Foot pain C ☐ Bursitis C ☐ Gout

Skin Conditions:

C ☐ Boils C ☐ Bruise easliy C ☐ Dryness C ☐ Eczema C ☐ Hives C ☐ Itching C ☐ Jaundice C ☐ Rash C ☐ Shingles C ☐ Varicose veins

Eyes, Ears, Nose & Throat Conditions:

C ☐ Deafness C ☐ Ear aches C ☐ Eye pain C ☐ Gum disease C ☐ Hoarseness C ☐ Nasal obstruction C ☐ Nose bleeds
C ☐ Ringing in ears C ☐ Sinus infection C ☐ Sore throat C ☐ Tonsilitis C ☐ Vision problems

Respiratory Conditions:

C ☐ Asthma C ☐ Bronchitis C ☐ Chronic cough C ☐ COPD C ☐ Coughing up phlem C ☐ Emphysema C ☐ Pneumonia
C ☐ Spitting up blood C ☐ Wheezing C ☐ Pain with breathing C ☐ Shortness of Breath

Cardiovascular Conditions:

C ☐ Arteriosclerosis C ☐ Heart disease C ☐ Hypertension C ☐ Hypotension C ☐ Irregular pulse C ☐ Pain over heart C ☐ Palpatations
C ☐ Poor circulation C ☐ Bradycardia C ☐ Tachycardia C ☐ Swelling in ankles

Gastrointestinal Conditions:

C ☐ Abdominal pain C ☐ Appendicitis C ☐ Bloated abdomen C ☐ Black stool C ☐ Bloody stool C ☐ Celiac Disease C ☐ Cirrhosis of liver
C ☐ Colitis C ☐ Crohn's disease C ☐ Constipation C ☐ Diarrhea C ☐ Difficult digestion C ☐ Diverticulitis C ☐ Excess gas
C ☐ Gall stones C ☐ Gastric reflux C ☐ Hernia C ☐ Hemorrhoids C ☐ Intestinal worms C ☐ Irritable Bowel C ☐ Leaky Gut Syndrome
C ☐ Nausea C ☐ Painful defication C ☐ Poor appetite C ☐ Stomach pain C ☐ Vomiting C ☐ Ulcers

Genitourinary Conditions:

C ☐ Bladder infections C ☐ Blood in urine C ☐ Impotence C ☐ Kidney infection C ☐ Kidney stones C ☐ Stress incontinence
C ☐ Bed wetting C ☐ Decreased flow or force C ☐ Painful urination

Male Specifc:

Date of last prostate exam: _____ / Findings: ☐ Negative *(nothing found)* ☐ Positive *(an abnormality was discovered)* ☐ Never had a prostate exam

Female Specifc:

Date of last PAP exam: _____ / Findings: ☐ Negative *(nothing found)* ☐ Positive *(an abnormality was discovered)* ☐ Never had a PAP exam

Date of last Mamogram: _____ / Findings: ☐ Negative *(nothing found)* ☐ Positive *(an abnormality was discovered)* ☐ Never had a Mamogram

Are you taking Birth Control medication? ☐ Yes ☐ No / If *Yes*, please indicate the name in the medication section on the next page

Are you Pregnant? ☐ Yes ☐ No / If *Yes*, how many months: _____

Menstrual Flow: ☐ Regular ☐ Regular with pain and/or camping ☐ Irregular ☐ Irregular with pain and/or camping

Patient Name _____ **Date** _____

Allergies *(please list all known allergies)* **:**

☐ Animal dander ☐ Animal hair ☐ Beef ☐ Corn ☐ Dairy ☐ Eggs ☐ Fish ☐ Fungus
☐ Latex ☐ Legumes ☐ Mold ☐ Nuts ☐ Peanuts ☐ Penicillin ☐ Pollen ☐ Ragweed
☐ Shellfish ☐ Soy ☐ Strawberries ☐ Wheat ☐ Other *(please describe)* :

Medication *(please list all medications that you are currently using)* **:**

Over-the-counter:
☐ Advil ☐ Alieve ☐ Acetaminophen ☐ Aspirin ☐ Ibuprophen ☐ Motrin ☐ Naproxen Sodium ☐ Tylenol

Prescribed Medication:
☐ Alendronate ☐ Chantix ☐ Crestor ☐ Cymbalta ☐ Darvocet ☐ Daytrana ☐ Estrogen ☐ Flexeril
☐ Hydrocodone ☐ Levoxyl ☐ Lipitor ☐ Morphine ☐ Norco ☐ Oxycontin ☐ Percocet
☐ Testosterone ☐ Ultram ☐ Valium ☐ Wellbutrin ☐ Zanaflex ☐ Zocor ☐ Zoloft

☐ Other *(please describe)* :

Vitamins, Minerals & Herbs *(please list all that you are currently using)* **:**

☐ Multivitamin ☐ Vitamin B ☐ Vitamin C ☐ Vitamin D ☐ Vitamin E

☐ Other *(please describe)* :

Surgeries & Hospitalization *(please list any surgeries and the years performed, the years you gave birth, any other reason for being hospitalized and the year)* **:**

Surgery: _____

_____

Births *(years)* : _____

Hospitalization: _____

_____

Injuries *(please list any previous auto accidents and the year, bone fractures and the year, sprains/strains and the year)* **:**

Injuries: _____

_____

Family History *(Please circle the family member "symbol" for any of the applicable diseases or illnesses)* **:**

F = Father / **M** = Mother / **B** = Brother / **S** = Sister / **PGF** = Paternal Grandfather / **PGM** = Paternal Grandmother / **MGF** = Maternal Grandfather / **MGM** = Maternal Grandmother

Alcoholism	F	M	B	S	PGF	PGM	MGF	MGM	Epilepsy	F	M	B	S	PGF	PGM	MGF	MGM
Anemia	F	M	B	S	PGF	PGM	MGF	MGM	Glaucoma	F	M	B	S	PGF	PGM	MGF	MGM
Arteriosclerosis	F	M	B	S	PGF	PGM	MGF	MGM	Heart disease	F	M	B	S	PGF	PGM	MGF	MGM
Arthritis	F	M	B	S	PGF	PGM	MGF	MGM	High blood presure	F	M	B	S	PGF	PGM	MGF	MGM
Asthma	F	M	B	S	PGF	PGM	MGF	MGM	High cholesterol	F	M	B	S	PGF	PGM	MGF	MGM
Bleed easily	F	M	B	S	PGF	PGM	MGF	MGM	Multiple Sclerosis	F	M	B	S	PGF	PGM	MGF	MGM
Cancer	F	M	B	S	PGF	PGM	MGF	MGM	Osteoporsis	F	M	B	S	PGF	PGM	MGF	MGM
Diabetes	F	M	B	S	PGF	PGM	MGF	MGM	Stroke	F	M	B	S	PGF	PGM	MGF	MGM
Emphysema	F	M	B	S	PGF	PGM	MGF	MGM	Thyroid disease	F	M	B	S	PGF	PGM	MGF	MGM

Personal Habbits *(please mark the appropriate options)* **:**

Alcohol	☐ Don't drink it	☐ 1-2 times per month	☐ drink 1-3 per week	☐ drink 1 per day	☐ drink 2 or more per day
Coffee	☐ Don't drink it	☐ drink 1-4 cups per week	☐ drink 1-3 cups per day	☐ drink 3 or more cups per day	
Tobacco	☐ Don't use it	☐ use light amounts	☐ use moderate amounts	☐ use heavy amounts	
Sleep	☐ Don't get regular sleep	☐ sleep 4-6 hours per night	☐ sleep 6-7 hours per night	☐ sleep 8 or more hours per night	
Soda	☐ Don't drink it	☐ drink 1-4 per week	☐ drink 1-2 per day	☐ drink 2-4 a day	☐ drink 4 or more a day
Water	☐ Don't drink it	☐ drink 1-3 cups per day	☐ drink 3-6 per day	☐ drink 6 or more cups a day	
Sugar	☐ Don't eat it	☐ eat light amounts	☐ eat moderat amounts	☐ eat heavy amounts	
Exercise	☐ Don't exercise	☐ engage in light exercise every week	☐ engage in moderate exercise every week	☐ engage in heavy exercise every week	