Name________________________________ Date____________

On this history form it is very important that you complete every question. This will allow the doctor/therapist to provide better health-care and to understand your health history. Any unanswered questions will delay your appointment time with the doctor. Please answer all questions truthfully and as accurately as possible. If you need help answering a question please ask for assistance from the front desk staff.

MEDICAL/SOCIAL HISTORY

Medical Conditions:

- ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Heart Disease
- ☐ Hypertension ☐ Psychiatric illness ☐ Skin Disorder ☐ Stroke

Surgeries:

- ☐ Appendectomy ☐ Cardiovascular procedure ☐ Cervical disc procedure ☐ Hysterectomy
- ☐ Joint replacement ☐ Laminectomies ☐ Radical prostatectomy ☐ Transuretheral prostate surgery

Allergies:

- ☐ Eggs ☐ Fish and Shellfish ☐ Milk or Lactose ☐ Peanut
- ☐ Soy ☐ Sulfites ☐ Wheat/Gluten

Social History:

- ☐ caffeine used occasionally ☐ caffeine used often ☐ chew tobacco occasionally ☐ chew tobacco often
- ☐ drink alcohol occasionally ☐ drink alcohol often ☐ exercise not at all ☐ exercise occasionally
- ☐ exercise often ☐ experience stress occasionally ☐ experience stress often ☐ smoke 1 pack or less per day
- ☐ smoke more than 1 pack a day ☐ wear seatbelts always ☐ wear seatbelts never ☐ wear seatbelts usually

Family History:

- ☐ arthritis (parent) ☐ arthritis (sibling) ☐ cancer (parent) ☐ cancer (sibling)
- ☐ cholesterol (parent) ☐ cholesterol (sibling) ☐ diabetes (parent) ☐ diabetes (sibling)
- ☐ heart problems (parent) ☐ heart problems (sibling) ☐ high blood pressure (parent) ☐ high blood pressure (sibling)
- ☐ psychiatric (parent) ☐ psychiatric (sibling) ☐ stroke (parent) ☐ stroke (sibling)
- ☐ thyroid (parent) ☐ thyroid (sibling)

Substance Use:

- ☐ Alcohol (past) ☐ Alcohol (present) ☐ Amphetamines (past) ☐ Amphetamines (present)
- ☐ Barbiturates (past) ☐ Barbiturates (present) ☐ Cocaine (past) ☐ Cocaine (present)
- ☐ Crystal Meth ☐ Heroin (past) ☐ Heroin (present) ☐ Marijuana (past)
- ☐ Marijuana (present)

Male Children:

- ☐ under 6 years ☐ under 10 years ☐ under 19 years

Female Children:

- ☐ under 6 years ☐ under 10 years ☐ under 19 years

Occupational Activities:

- ☐ administration ☐ business owner ☐ clerical/secretarial ☐ computer user
- ☐ construction ☐ daycare/childcare ☐ executive/legal ☐ food service industry
- ☐ healthcare ☐ heavy equipment operator ☐ heavy manual labor ☐ home services
- ☐ household ☐ light manual labor ☐ manufacturing ☐ medium manual labor
- ☐ military ☐ police/fire ☐ professional services ☐ retail worker
- ☐ teacher ☐ truck driver

Recreational Activities:

- ☐ backpacking ☐ biking ☐ boating ☐ football
- ☐ golf ☐ racket ball ☐ running ☐ skiing
- ☐ soccer ☐ swimming ☐ tennis ☐ walking
- ☐ weight lifting

REVIEW OF SYSTEMS

Have you had trouble with any of the following:

Cardiovascular: No ☐

	Present	Past	No
Poor Circulation	○	○	○
High Blood Pressure	○	○	○
Aortic Aneurism	○	○	○
Heart Disease	○	○	○
Vascular Disease	○	○	○
Heart Attack	○	○	○
Chest Pain	○	○	○
High Cholesterol	○	○	○
Pace Maker	○	○	○
Jaw Pain	○	○	○
Irregular Heartbeat	○	○	○
Swelling of Legs	○	○	○

Genitourinary: No ☐

	Present	Past	No
Kidney Disease	○	○	○
Lower Side Pain	○	○	○
Burning Urination	○	○	○
Frequent Urination	○	○	○
Blood in Urine	○	○	○
Kidney Stone	○	○	○

Hematologic/Lymphatic: No ☐

	Present	Past	No
Hepatitis	○	○	○
Blood Clots	○	○	○
Cancer	○	○	○
Easy Bruising	○	○	○
Easy Bleeding	○	○	○
Fevers/Chills/Sweats	○	○	○

Respiratory: No ☐

	Present	Past	No
Asthma	○	○	○
Tuberculosis	○	○	○
Shortnes of Breath	○	○	○
Emphysema	○	○	○
Cold/Flu	○	○	○
Cough/Wheezing	○	○	○

Ears/Nose/Throat: No ☐

	Present	Past	No
Dizziness	○	○	○
Hearing Loss	○	○	○
Sinus Infection	○	○	○
Nosebleed	○	○	○
Sore Throat	○	○	○
Difficulty Swallowing	○	○	○
Bleeding Gums	○	○	○

Eyes: No ☐

	Present	Past	No
Glaucoma	○	○	○
Double Vision	○	○	○
Blurred Vision	○	○	○

Integumentary: No ☐

	Present	Past	No
Skin Lesions	○	○	○
Skin Ulcers	○	○	○
Skin Disease	○	○	○
Eczema	○	○	○
Psoriasis	○	○	○
Rashes	○	○	○

Allergic/Immunologic: No ☐

	Present	Past	No
Hives	○	○	○
Immune Disorder	○	○	○
HIV/AIDS	○	○	○
Allergy Shots	○	○	○
Cortisone Use	○	○	○

Gastrointestinal: No ☐

	Present	Past	No
Galbladder Problems	○	○	○
Bowel Problems	○	○	○
Constipation	○	○	○
Liver Problems	○	○	○
Ulcers	○	○	○
Diarrhea	○	○	○
Nausea/Vomiting	○	○	○
Bloody Stools	○	○	○
Poor Appetite	○	○	○

Musculoskeletal: No ☐

	Present	Past	No
Gout	○	○	○
Arthritis	○	○	○
Joint Stiffness	○	○	○
Muscle Weakness	○	○	○
Osteoporosis	○	○	○
Broken Bones	○	○	○
Joints Replaced	○	○	○

Endocrine: No ☐

	Present	Past	No
Thyroid Disease	○	○	○
Diabetes	○	○	○
Hair Loss	○	○	○
Menopausal	○	○	○
Menstrual Problems	○	○	○

Psychiatric: No ☐

	Present	Past	No
Depression	○	○	○
Anxiety Disorder	○	○	○
Unusual Stress	○	○	○

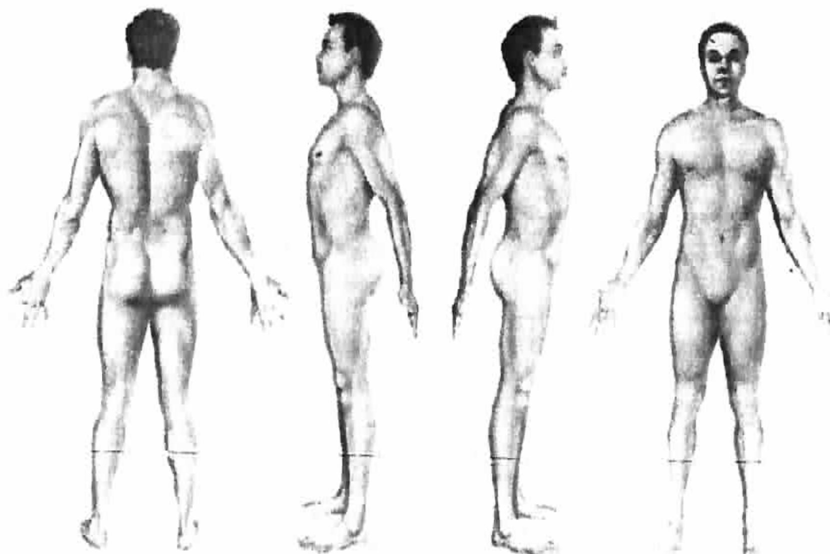
Constitutional: No ☐

	Present	Past	No
Weight Loss/Gain	○	○	○
Energy Level Problem	○	○	○
Difficulty Sleeping	○	○	○

Neurological: No ☐

	Present	Past	No
Babinski	○	○	○
Stroke	○	○	○
Seizures	○	○	○
Head Injury	○	○	○
Brain Aneurysm	○	○	○
Numbness	○	○	○
Severe Headaches	○	○	○
Pinched Nerves	○	○	○
Parkinson's Disease	○	○	○
Carpal Tunnel	○	○	○
Spinning/Balance	○	○	○

Using the symbols below, mark on the pictures where you feel pain:



☐ Numbness (#) ☐ Burning (x) ☐ Stabbing (/) ☐ Pins & Needles (0) ☐ Dull Ache (+) ☐ Pain (*)