|  |  |
| --- | --- |
| Name: |  |

**HELTH HISTORY**

Please indicate whether you have experienced any of the following relating to your current condition:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Fever / Chills |  | Allergies |  | Shoulder/Elbow/Hand Pain |  |
| Headaches |  | Arthritis |  | Hip/Knee/Foot Pain |  |
| Migraines |  | Loss of Balance |  | Numbness in Fingers |  |
| Stiff Neck |  | Loss of Taste |  | Numbness in Toes |  |
| Neck Pain |  | Loss of Smell |  | Shortness of Breath |  |
| Back Pain |  | Difficulty Urinating |  | Chest Pain / Tightness |  |
| Tension |  | Unusual Bowel Patterns |  | High Blood Pressure |  |
| Nervousness |  | Hands Cold |  | Indigestion Problems |  |
| Irritability |  | Feet Cold |  | Weight Loss / Gain |  |
| Dizziness |  | Sinus Problems |  | Diabetes |  |
| Fainting |  | Ringing in Ears |  | Joint Pain / Swelling |  |
| Weakness |  | Depression |  | Fatigue |  |
| Muscle Spasms |  | Sleeping Problems |  | Loss of Memory |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Women: Menstrual Difficulties | | |  |
| Are you pregnant? |  | | |
| Date of Last Period |  | | |
| Date of Last Pap |  | | |
| Date of Last Mammogram | |  | |

**SOCIAL HISTORY**

Please indicate whether you engage in these: **OFTEN = √ SOMETIMES = S NEVER = X**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Caffeine Intake |  | Social Pressures |
|  | Tobacco Use |  | Financial Pressures |
|  | Alcohol Use |  | High Stress Activity |
|  | Drug Use |  | Other (please specify) |
|  | Exercise |  | |

**FAMILY HISTORY**

Please indicate diseases and conditions that are current health problems of my family member.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Condition |  | Family Member |  | Age |  |
| Condition |  | Family Member |  | Age |  |
| Condition |  | Family Member |  | Age |  |

Health/Social/Family History