Name:
Chart:
Date:

HEALTH HISTORY FORM

Name: _____ Phone: _____ Birth Date: _____ Age: _____

What problem are you being seen for today? _____

Date/Place/When/How Occurred: _____

Primary Care Physician: _____ Referred By: _____

Height: _____ Weight: _____ Prior Treatment? Yes ☐ No ☐ Prior X-Rays? Yes ☐ No ☐

Patient Signature: _____ **Date:** _____

DRUG ALLERGIES

_____

CURRENT MEDICATIONS

Medication Dosage

_____

_____

_____

WORK AND SOCIAL HISTORY

Occupation: _____

Does your work involve heavy lifting? ☐ Yes ☐ No

Standing for long periods of time? ☐ Yes ☐ No

Sitting for long periods of time? ☐ Yes ☐ No

What do you do for exercise? _____

Smoking Status? ☐ Current ☐ Never ☐ Previous

Alcohol Drinks Per Day? ☐ Non-Drinker ☐ 1-2 ☐ 3 or More

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

WOMEN ONLY: Pregnant? ☐ Yes ☐ No Planning Pregnancy? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Please check if you have a past medical history of the following:

☐ Allergies _____ ☐ Depression _____ ☐ Kidney Disease _____

☐ Anemia _____ ☐ Diabetes _____ ☐ Pneumonia _____

☐ Anesthetic problems _____ ☐ MRSA or Chronic Infections _____ ☐ Prostate disease _____

☐ Arthritis _____ ☐ Digestive disorder/Ulcer _____ ☐ Osteoporosis _____

☐ Asthma _____ ☐ Gout _____ ☐ Tetanus _____

☐ Blood Clot/DVT _____ ☐ Heart problems _____ ☐ Tuberculosis/TB _____

☐ Cancer/What Type _____ ☐ Hepatitis _____ ☐ Thyroid Disease _____

☐ Chronic rashes ☐ High Blood Pressure ☐ AIDS/HIV

FAMILY MEDICAL HISTORY

Please mark any of the conditions that your mother (M), father (F), brother (B), or sister (S) has or had:

☐ Heart disease _____ ☐ Diabetes _____ ☐ Osteoporosis _____

☐ High blood pressure _____ ☐ Arthritis _____ ☐ Other _____

☐ Bleeding problems ☐ Cancer

REVIEW OF SYMPTOMS

Please check if you are currently experiencing any of the following symptoms:

☐ Fever	☐ Bladder incontinence	☐ Blood in Stools	☐ Numbness
☐ Chills	☐ Diarrhea	☐ Abdominal pain	☐ Tingling
☐ Night sweats	☐ Constipation	☐ Headaches	☐ Weakness
☐ Unexplained weight loss	☐ Nausea	☐ Blurred Vision	☐ Chest pain
☐ Bowel incontinence	☐ Wheezing	☐ Joint Pain	☐ Palpitations
☐ Shortness of breath	☐ Vomiting	☐ Difficulty swallowing	☐ Other

CLINICAL STAFF OR PHYSICIAN REVIEW

Reviewed by: _____ Date: _____ Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____ Reviewed by: _____ Date: _____