Patient Health History

Name: ____ Date: ______________

DOB: ________________ Height: _____________ Weight: _____________ M or F

Please indicate if you have or have had any of the following conditions. This is a confidential health report.

- ☐ Neck pain/stiffness
- ☐ Back pain/stiffness
- ☐ Arm/elbow/hand pain
- ☐ Hip/knee/leg pain
- ☐ Ankle/foot pain
- ☐ Headaches
- ☐ Arthritis
- ☐ Dizziness
- ☐ Asthma
- ☐ Tingling in arms
- ☐ Tingling in legs
- ☐ Sciatica
- ☐ Joint swelling
- ☐ Fatigue
- ☐ Sleeping difficulties
- ☐ Allergies
- ☐ Blurred vision
- ☐ Depression
- ☐ Nervousness
- ☐ Tension
- ☐ Cold sweats
- ☐ Night pain
- ☐ Sudden weight loss
- ☐ Jaw/TMJ problems
- ☐ Constipation
- ☐ Diarrhea
- ☐ Acid Reflux
- ☐ Nausea
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Wheezing
- ☐ Gallbladder problems
- ☐ Liver problems
- ☐ Kidney infections
- ☐ Kidney stones

- ☐ Fever
- ☐ Fainting
- ☐ Sinus infections
- ☐ Bowel/bladder changes
- ☐ Hemorrhoids
- ☐ Arteriosclerosis
- ☐ Heart disease
- ☐ Hypertension
- ☐ Hypotension
- ☐ Swelling of ankles
- ☐ Thyroid problems
- ☐ Goiter
- ☐ Eczema
- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Autoimmune Disease
- ☐ Loss of Appetite
- ☐ Bleeding disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Hernia
- ☐ Herniated disc
- ☐ Measles
- ☐ Mumps

- ☐ Malaria
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problems
- ☐ Prosthesis/Crutch
- ☐ Rheumatoid arthritis
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease/STD
- ☐ Whooping cough

Women only:

- ☐ Menstrual cramps
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Lumps in breast
- ☐ Menopausal symptoms
- ☐ Painful menstruation
- ☐ Vaginal discharge/infection
- ☐ Miscarriages
- ☐ Pregnant
- ☐ Date of last period: ________

Family History: (Please indicate any conditions in family)

- ☐ Inflammatory Arthritis (Rheumatoid, Psoriatic)
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Neurologic Disorders (Parkinson's, Multiple Sclerosis, Lou Gehrig's, etc.)
- ☐ Autoimmune Diseases (Lupus, Scleroderma, etc.)

Other: ____

Patient Health History

Name: ____ Date: ____________

Date of last physical examination (within the last year): ____________________

Date of last blood work (within the last year): ____________________

List any medications you are currently taking:

____

____

List any vitamins/supplements/herbs you are currently taking:

____

____

List any surgeries/hospitalizations you have had:

____

____

List any known allergies:

____

____

List any broken bones/fractures you have had:

____

____

Do your work activities mostly involve:

__ Sitting __ Standing __ Light labor __ Heavy labor

What is your daily/weekly intake of the following:

Coffee: ____cups/day Soft drinks: ____cups/day Alcohol: __drinks/week

Cigarettes: ____packs/day Smokeless tobacco: ____ x/day

What is the intensity of your exercise? ___Heavy ___Moderate ___Light ___None

After reading and filling out the health history, your signature will verify that all the information you have given us is accurate and you have read all the history questions.

Signature: ______________________________________ Date: ________________