HEALTH HISTORY

Date____/____/____ File #:________________

NAME

____

Last First Middle

SEX: ❑ Male ❑ Female DATE OF BIRTH_____/_____/_____

What is the reason for your visit?

____

____

What do you think caused this problem?

____

____

PERSONAL HEALTH HISTORY

Please list any medical conditions or symptoms you are currently experiencing, or have experienced during the past year:

____

____

____

____

Please tell us about any hospitalizations, serious illnesses or surgeries:

Year	Reason	Hospital	Outcome

List your prescribed medications, over-the-counter medications, herbs, vitamins and inhalers:

Name	Dosage	Frequency Used

Please provide details of any known allergies (e.g., latex, medications, foods)

Allergen	Reaction

HEALTH HABITS

EXERCISE

❏ Sedentary (No Exercise)
❏ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
❏ Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 min.)
❏ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 min.)

DIET

Are you Dieting? ❏ Yes ❏ No

If yes, are you on a physician prescribed medical diet? ❏ Yes ❏ No

Number of meals you eat in an average day _________

Please rate the quality of your diet *Perfect* 0 1 2 3 4 5 6 7 8 9 10 *Terrible*

CAFFEINE

❏ None ❏ Coffee ❏ Tea ❏ Cola Number of Cups/Cans Per Day_______

ALCOHOL / TOBACCO

How many alcohol containing beverages do you consume daily_______ weekly_______

Do you use tobacco? ❏ Yes ❏ No Cigarettes

Number of packs A Day_______ A Year_______ ❏ or Year Quit_______

SLEEP

Does your complaint disrupt your sleep? ❏ Yes ❏ No

How do you rate the quality of your sleep? *Perfect* 0 1 2 3 4 5 6 7 8 9 10 *Terrible*

Do you use a special neck pillow? ❏ Yes ❏ No

STRESS

Please rate your stress management strategies *Perfect* 0 1 2 3 4 5 6 7 8 9 10 *Terrible*

Please rate your daily stress level *Perfect* 0 1 2 3 4 5 6 7 8 9 10 *Terrible*

PREGNANCY / CHILDREN

_______________ # of Pregnancies

_______________ # Birth Children

_______________ # Cesarean Sections

FAMILY HEALTH HISTORY

Please help us to identify your potential health risks by placing a check in any column that applies to you or your blood relatives.

Condition / Body System	Self	Grandparent	Parent	Sibling	Child
Aids / HIV					
Arthritis					
Bleeding Disorders					
Cancer					
Endocrine/Glandular (diabetes, thyroid)					
Hepatitis					
Stroke / TIA					
Circulatory Problems (blood vessels, heart)					
Ear, Nose, Throat					
Heart Problems					
High Blood Pressure					

Neurological (brain, nerves)					
Gastrointestinal (stomach, intestines)					
Muscle / Joint / Bone					
Genitourinary (urinary, kidney, prostate)					
Psychological					
Respiratory (lung, breathing)					
Skin					

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in completion of this form.

Patient Signature

Date