Patient Health History

Name: _____ **Date:**_____
DOB: _____

For all patients-you must complete the next section.

****Allergies:** please list any allergies:

_____

****OCCUPATION:** _____

Chief Complaint: What is the reason for your visit today? (Please describe problem in detail including history of present illness):_____

History of Present Illness:
Location: _____ **Duration:** _____(how long does it last?)
Severity: **Rate the rate from 1-10 (1 = mild, 10 = severe)** _____
When does the Pain occur? _____ (examples: after meals, after exercise, while walking)
Is the pain burning? ❑ Yes ❑ No Is the pain stabbing? ❑ Yes ❑ No

Past Medical History: Please check all that apply to you:

❑ Arthritis	❑ Cancer	❑ Depression	❑ Diabetes
❑ Epilepsy/seizures	❑ Heart problems	❑ Heart surgery	❑ High blood pressure
❑ Psychiatric disease	❑ Stroke	❑ Thyroid	❑ None

Previous Surgeries: Please list past surgeries with approximate date: _____
_____

Serious Injury: Please describe any serious injuries you have had: _____
_____

Medications: Please list any medications you are taking with dose and frequency:

ARE YOU TAKING ANY ASPIRIN (even baby aspirin) products? ❑Yes ❑No
ARE YOU TAKING PLAVIX? ❑Yes ❑No
ARE YOU TAKING ANY BLOOD THINNING MEDICATIONS? ❑Yes ❑No

Drug	***Dose/Frequency***
_____	_____
_____	_____
_____	_____
_____	_____

Social History:
Do you drink alcohol? ❑Yes ❑No If yes, how much/week? _____
Do you smoke? ❑Yes ❑No If yes, how many cigarettes/day? _____
Do you consume caffeine? ❑Yes ❑No If yes, how many cups/week?_____
Do you use recreation drugs? ❑Yes ❑No If yes, what type and frequency? _____
Are you on a special diet? ❑Yes ❑No If yes, please describe? _____

Family History: Do you know of any blood relative who has or had:

❑ Asthma	❑ Aneurysm	❑ Brain Tumor	❑ Cancer, Type: _____
❑ Diabetes	❑ Epilepsy/Seizures	❑ Headaches	❑ Heart Problems
❑ High blood pressure	❑ Kidney disease	❑ Lung Disease	❑ Migraine
❑ Multiple Sclerosis	❑ Psychiatric Disease	❑ Stroke	❑ Thyroid
❑ None			

Comments: _____

Patient Health History

As you review the following list, please check any problems or conditions, that you are experiencing or have experienced. If you do not have any of the problems listed in the section please check none.

General Health

❑ Good general health ❑ Recent weight change ❑ Loss of appetite
❑ Fatigue ❑ Fever/chills

Ears, Nose, Mouth, Throat

❑ Sore throat/voice change ❑ Loss of hearing/deafness ❑ Nose Bleeds
❑ Loss of taste ❑ Painful chewing ❑ Ringing in ears ❑ Sinus infection
❑ Sores in mouth ❑ **None** ❑ Other: _____

Eyes

❑ Wear glasses ❑Yes ❑No ❑ Wear contact lenses? ❑Yes ❑No ❑ Blurred vision./double vision
❑ Loss of vision ❑ **None**

Gastrointestinal

❑ Blood in stools ❑ Increasing constipation ❑ Nausea ❑ Painful bowel movements
❑ Persistent diarrhea ❑ Stomach or abdominal pain ❑ Ulcer ❑ Vomiting/Nausea
❑ Other: _____ ❑ **None**

Genitourinary

❑ Blood in urine ❑ Female: irregular periods ❑ Female: #pregnancies_____ #miscarriages_____
❑ Female: vaginal discharge ❑ Kidney stones ❑ Male: prostate disease
❑ Male: testicle pain ❑ Painful or burning urination ❑ Sexual difficulty ❑ Sexually transmitted disease
❑ Urgency with urination ❑ Urine retention/incontinence ❑ Other: _____ ❑ **None**

Heart and Lungs

❑ Pain in chest ❑ High blood pressure ❑ High cholesterol ❑ Irregular heart beat
❑ Other: _____ ❑ **None**

Muscles/Joints/Bones

❑ Back pain ❑ Difficulty walking ❑ Joint pain ❑ Joint stiffness or swelling
❑ Muscle pain or tenderness ❑ Neck pain ❑ **None**

Endocrine

❑ Excessive thirst/urination ❑ Thyroid disease ❑ Hormone problems ❑ **None**

Neurological

❑ Frequent headaches ❑ Paralysis or tremors ❑ Convulsions/seizures
❑ Light-headed or dizziness ❑ Migraines ❑ Numbness or tingling ❑ Stroke
❑ Tremors ❑ Weakness ❑ Other: _____
❑ **None**

Psychiatric

❑ Depression ❑ Anxiety ❑ Insomnia
❑ Eating disorder ❑ Other: _____ ❑ **None**

Respiratory

❑ Asthma ❑ Blood in cough ❑ Chronic or frequent cough
❑ Shortness of breath ❑ Other: _____ ❑ **None**

Sleep

❑ Snoring ❑ Sleepwalking Do you sleep well? ❑Yes ❑No
Do you feel rested when you wake? ❑Yes ❑No Do you fall asleep during the day? ❑Yes ❑No