



Health History

Patient's Name

Date of Birth

Date

Please check all that apply. Have you been diagnosed with any of the following medical conditions?

- | | | |
|--|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Bladder/Kidney Problems | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Intestinal Problems/IBS | <input type="checkbox"/> Difficulty Swallowing |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Muscle Problems | Thyroid: Hypo ____ Hyper ____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological Issues | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Emphysema/Asthma | <input type="checkbox"/> Psychological Issues | _____ |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Respiratory Issues | _____ |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Rheumatic Fever | _____ |

Are you currently using any of the following?

- | | | |
|---|---|---|
| Antibiotics | Y | N |
| Anticoagulants | Y | N |
| Insulin | Y | N |
| NSAIDS (Aspirin, Ibuprofen, Motrin, Aleve, etc) | Y | N |
| High Blood Pressure Medication | Y | N |

Allergies: Do you have any medication allergies? Y N
If so, please list the medication and the type of reaction you had:

Surgeries: Please list all surgeries you have had with the approximate year.
Year Surgery

Family History: Circle and complete the following questions.

Is your biological father: Living Deceased
Age? _____ Health Conditions? _____

Is your biological mother: Living Deceased
Age? _____ Health Conditions? _____

Social History: Please answer the following questions.

Do you smoke? Y N Number of packs per day: _____ How many years? _____

Do you use recreational drugs? Y N If yes, what type and how often? _____

Do you get exercise? Y N What kind? _____ How often? _____

Marital Status: Single Married Divorced Widow

Do you have any children? Y N # of Boys: _____ # of Girls: _____

Do you use alcohol? Y N How often? _____

What is your occupation? _____

Are you currently on or seeking disability? Y N

Is the current complaint work or auto related? Work Auto

Circle any of the following symptoms that you have experienced with your current complaint:

Fever Chills Night Sweats Loss of Appetite
Fatigue Weight Loss Weight Gain Trouble Sleeping

Circle the words that describe your pain:

Aching Burning Cold Cramping Dull Fire Hot
Pinching Pressure Numb Sharp Squeezing Spasm
Shooting Stabbing Shock Stinging Tender Throbbing

Circle any of the following pain medications have you tried:

Morphine MS Contin Lortab Oxycontin Vicodin Duragesic Patch
Percocet Demerol Baclofen Lidoderm Vicoprofen Bextra
Soma Ultracet Ultram Darvocet Neurontin Trileptal
Lyrica Zonegran Lamictal Topamax Mobic Ibuprofen
Naprosyn Celebrex Cymbalta Elavil Trazadone Effexor

Circle any of the following symptoms you have experienced related to your eyes:

Irritation Drainage Blurring Loss of Vision Pain Yellow Color

Circle any of the following symptoms you have experienced recently:

Recent Cough or Cold Coughing Blood Nose Bleed Hearing Loss Change in Voice
Sore Throat Ringing in Ears Ear Pain Hoarseness Difficulty
Swallowing Coughing Blood

Circle any of the following symptoms you have experienced:

Chest Pain	Palpitations	Dizziness	Fainting Spells	Shortness of Breath
Need to Sleep with More than 1 Pillow			Leg Swelling	Cold Extremities
Shortness of Breath	Excessive Sputum Production	Blood in Sputum	Wheezing	
Nausea	Tarry Stools	Jaundice	Vomiting	Difficulty Swallowing
Abdominal Pain	Diarrhea	Constipation	Blood in Stools	
Blood in Urine	Urinary Urgency	Frequent Urination	Incontinence	
Recurrent Urinary Tract Infections		Frequent Urination at Night	Impotence	
Decreased Sex Drive	Painful Urination	Urinary Retention		
Leg cramps	Joint Pain	Joint Swelling	Joint Stiffness	
Back Pain	Muscle Cramps	Muscle Weakness	Arthritis	
Seizures	Headaches	Memory Loss	Dizziness	Tingling in Extremities
Fainting Spells	Tremors	Vertigo	Paralysis	
Depression	Sleep Disturbances	Suicidal ideation	Eating Disorders	
Mental Illness	Anxiety			
Cold Intolerances	Heat Intolerances	Excess Urination	Excess Thirst	
Excess Sweating				
Abnormal Bleeding	Abnormal Bruising	Varicose Veins	Enlarged Lymph Nodes	
HIV Exposure	Persistent Infections	Hay Fever	Itching	

**Please make a list of ALL medications and dosages
(including over-the-counter medications and vitamins).**

**Please complete this paperwork and bring it with you to your appointment.
If you desire, you may fax all paperwork to (816) 777-1200 or mail it to
9501 N. Oak Trafficway, Suite 201, Kansas City, MO 64155.**

If you have any questions, please call (816) 420-8282.

**Thank you for choosing us for your care!
We look forward to meeting you.**