



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: Kind _____ | <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 Problems | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Emphysema/Asthma | <input type="checkbox"/> Psychological Problems | _____ |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Respiratory Problems | _____ |
| <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:

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

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

Social History:

Do you smoke? Y N # of packs per day: _____ How many years? _____
Do you use recreational drugs? Y N If yes, what type and how often? _____
Do you exercise? Y N What kind? _____ How often? _____
Marital Status: Single Married Divorced Widow
Do you have 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: On or Seeking N
Is the current complaint work or auto related? Work Auto

Circle any 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

For this condition, circle any of the following medications you have 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 Trazodone Effexor
Suboxone Opana Lithium Dilaudid Kadian Avinza
Exalgo Buspar Savella Norco Nucynta Butrans

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

