HEALTH HISTORY

Welcome! As a new patient, we ask you fill out the information below completely and to the best of your ability.

Today's Date:_____

Patient Name _____ Birthdate _____ Account # Acct #

Chief Complaint: _____

History of present illness:

Location: _____ **Timing:** _____
(Where is the pain/problem?) (Does the pain/problem occur at specific time?)

Associated signs/symptoms: _____ **Context:** _____

_____ _____
(What other associated problems have you been having?) (Where were you at the onset of the pain/problem?)

Is problem work/ auto related? (circle one) Yes / No
Date of injury: ____/____/_____
Date reported to Employer/ Insurance: ____/___/_____

Severity of Pain: (please circle)
0 1 2 3 4 5 6 7 8 9 10
Low > > > > > > > > > > > High

Past Medical History: Have you every had the following: (circle yes or no)

Rheumatic Fever	yes	no	Anemia	yes	no	Back trouble	yes	no
Heart Disease	yes	no	Bladder infections	yes	no	High Blood Pressure	yes	no
Arthritis	yes	no	Epilepsy	yes	no	Low Blood Pressure	yes	no
Migraines	yes	no	Tuberculosis	yes	no	Asthma	yes	no
Diabetes	yes	no	Cancer	yes	no	Glaucoma	yes	no
Hives or Eczema	yes	no	Aids or HIV+	yes	no	Bronchitis	yes	no
Stroke	yes	no	Hepatitis	yes	no	Ulcer	yes	no
Kidney Disease	yes	no	Thyroid Disease	yes	no	Bleeding Tendency	yes	no
Lyme Disease	yes	no	Gout	yes	no	Pacemaker/Defibrillator	yes	no

Previous Hospitalizations/Surgeries/Serious Illnesses	**When?**	**Hospital, City, State**
_____	_____	_____
_____	_____	_____

Allergies History of skin reaction or other adverse reaction to: ☐ **No Known Drug Allergies**

			Reaction:
Adhesive Tape	yes	no	_____
Antibiotics	yes	no	_____
Aspirin or other pain remedies	yes	no	_____
Codeine/ Demerol/ Morphine or other Narcotics	yes	no	_____
Iodine or other antiseptics	yes	no	_____
Latex	yes	no	_____
Novocain or other anesthetics	yes	no	_____
Penicillin	yes	no	_____
Shrimp/ Iodine	yes	no	_____
Sulfa Drugs	yes	no	_____
Any other Drug/food allergy: Name:			_____

Patient Social History: (please circle)

Use of alcohol: Never / Rarely / Moderate / Daily: _____

Use of tobacco: Never / Previously, but quit: _____ Current pack / Day: _____ Type: Cigarette / Cigar / Chewing

Use of drugs: Never / Type/Frequency: _____

Family Medical History:

	Age	Diseases
Father	_____	_____
Mother	_____	_____
Siblings	_____	_____
Children	_____	_____

Review of Systems: Please indicate any personal history below:

☐ **Cardiovascular**

Heart trouble	yes	no
Chest pain or angina pectoris	yes	no
Palpitation	yes	no
Shortness of breath w/ walking or lying flat	yes	no
Swelling of feet, ankles/ hands	yes	no

☐ **Respiratory**

Do you have a persistent cough / throat clearing not associated with a known illness (lasting more than 3 weeks	yes	no
Spitting up blood	yes	no
Shortness of breath	yes	no
Wheezing	yes	no

☐ **Gastrointestinal**

Loss of appetite	yes	no
Change in bowel movements	yes	no
Nausea or vomiting	yes	no
Frequent diarrhea	yes	no
Painful bowel movements	yes	no
Rectal bleeding / blood in stool	yes	no
Abdominal pain	yes	no

☐ **Genitourinary**

Frequent urination	yes	no
Burning/ painful urination	yes	no
Blood in urine	yes	no
Change in force of strain when urinating	yes	no
Incontinence or dribbling	yes	no
Kidney stones	yes	no

☐ **Musculoskeletal**

Joint pain	yes	no
Joint stiffness or swelling	yes	no
Weakness of muscles / joints	yes	no
Muscle pain or cramps	yes	no
Back pain	yes	no
Cold extremities	yes	no
Difficulty in walking	yes	no

☐ **Integumentary (skin,nails)**

Rash or itching	yes	no
Change in skin color	yes	no
Change in hair or nails	yes	no
Varicose veins	yes	no
Athletes foot	yes	no
Dry skin	yes	no
Nail abnormalities	yes	no
Ingrown Nail	yes	no
Corns / Callouses	yes	no
Warts	yes	no

☐ **Neurological**

Frequent / recurring headache	yes	no
Light headed or dizzy	yes	no
Convulsions or seizures	yes	no
Numbness or tingling	yes	no
Tremors	yes	no
Paralysis	yes	no
Head injury	yes	no
Alzheimer's	yes	no

☐ **Hematologic/ Lymphatic**

Slow to heal after cuts	yes	no
Bleeding/ bruising tendency	yes	no
Anemia	yes	no
Phlebitis	yes	no
Past transfusion	yes	no
Enlarged glands	yes	no

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the Healthcare staff to perform the necessary services I may need.

_____ _____

Signature of Patient, Parent, Guardian, POA Date

Doctor's Review:

_____ _____

Signature of Doctor Date