# HEALTH HISTORY    Date: ______________

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***All information is treated as strictly confidential. The more fully you complete this form, the better we will be able to diagnose and treat you.***

**Name:** ________________________________________________ **DOB:** ________________________

| **Office Use Only** | ______________ | ______________ | ______________ |
|---|---|---|---|

## CHIEF COMPLAINT (Why are you seeing doctor today?)

Type of injury/illness: ______________________________________________________________

Area of Body: ☐ Head ☐ Neck ☐ Back ☐ Other ____________________ Date Started: ________________________

What do you feel caused this? ______________________________________________________

If Accident Related - Type: ☐ Auto ☐ Workers Comp ☐ Other ____________________

How bad is your pain on a scale of 1-10 (1 being best & 10 being worst) At its Best: ________ At its Worst: ________

What makes it - Better______________________________________ Worse______________________________________

Have you seen other doctors for this condition? ☐ Yes ☐ No if yes, who____________________________________

What medical tests have been performed? _______________________________________________

Have you been disabled, fired, or unable to work due to this problem? ☐ Yes ☐ No

Are you currently involved in any litigation regarding this problem? ☐ Yes ☐ No

| **MEDICAL ALLERGIES** | **ALLERGY SYMPTOMS** |
|---|---|
| ________________________________ | ________________________________ |
| ________________________________ | ________________________________ |
| ________________________________ | ________________________________ |

| **CURRENT MEDICATIONS** (RX or OTC) | **STRENGTH / DOSAGE** (attach list for numerous meds) |
|---|---|
| ________________________________ | ________________________________ |
| ________________________________ | ________________________________ |
| ________________________________ | ________________________________ |
| ________________________________ | ________________________________ |
| ________________________________ | ________________________________ |
| Blood Thinner's? ____________________ | ________________________________ |

**SOCIAL HISTORY** Occupation: ______________________________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Children: ☐ Yes ☐ No How Many? ______________

Do you Smoke? ☐ Yes ☐ No ☐ Quit ______ how long ☐ Never Smoked

☐ Cigarettes ______ packs per day for ______ year's ☐ Cigars/Pipe ☐ Smokeless Tobacco

Do you drink Alcohol? ☐ Never ☐ Rarely ☐ Socially ☐ Regularly

| **SURGERIES** | **YEAR** | **ANY COMPLICATIONS** |
|---|---|---|
| ____________________ | ____________ | ______________________________ |
| ____________________ | ____________ | ______________________________ |
| ____________________ | ____________ | ______________________________ |

| **FAMILY HISTORY** | Alive | Age | Medical Problems | Deceased | Cause of Death |
|---|---|---|---|---|---|
| Grandfather (father's side) | ☐ | ____ | ____________________ | ☐ | ____________________ |
| Grandmother (father's side) | ☐ | ____ | ____________________ | ☐ | ____________________ |
| Grandfather (mother's side) | ☐ | ____ | ____________________ | ☐ | ____________________ |
| Grandmother (mother's side) | ☐ | ____ | ____________________ | ☐ | ____________________ |
| Father | ☐ | ____ | ____________________ | ☐ | ____________________ |
| Mother | ☐ | ____ | ____________________ | ☐ | ____________________ |
| Sister/Brother | ☐ | ____ | ____________________ | ☐ | ____________________ |
| Sister/Brother | ☐ | ____ | ____________________ | ☐ | ____________________ |

## MEDICAL REVIEW

Check all that apply

| | Current Problem | Past Problem |
|---|---|---|
| **Allergy / Immunological** | | |
| Asthma | ☐ | ☐ |
| Hives | ☐ | ☐ |
| Immune Deficiency | ☐ | ☐ |
| Swelling | ☐ | ☐ |
| **Constitutional / General Body** | | |
| Excessive Fatigue | ☐ | ☐ |
| Fever | ☐ | ☐ |
| Weight Gain | ☐ | ☐ |
| Weight Loss | ☐ | ☐ |
| **Ear, Nose, Throat, & Mouth** | | |
| Balance Problems | ☐ | ☐ |
| Ear Pain | ☐ | ☐ |
| Hearing Loss | ☐ | ☐ |
| Inability to Smell | ☐ | ☐ |
| Nosebleeds | ☐ | ☐ |
| Ringing of Ears | ☐ | ☐ |
| **Eyes** | | |
| Cataracts | ☐ | ☐ |
| Glaucoma | ☐ | ☐ |
| Injuries | ☐ | ☐ |
| Vision Loss | ☐ | ☐ |
| **Endocrine** | | |
| Diabetes Type I | ☐ | ☐ |
| Diabetes Type II | ☐ | ☐ |
| Excessive Thirst | ☐ | ☐ |
| Excessive Urination | ☐ | ☐ |
| Hormone Problems | ☐ | ☐ |
| Thyroid Problems | ☐ | ☐ |
| **Gastrointestinal** | | |
| Abdominal Pain | ☐ | ☐ |
| Blood in Stool | ☐ | ☐ |
| Blood in Vomit | ☐ | ☐ |
| Colon Cancer | ☐ | ☐ |
| Constipation | ☐ | ☐ |
| Jaundice | ☐ | ☐ |
| Liver Disease | ☐ | ☐ |
| Nausea | ☐ | ☐ |
| Vomiting | ☐ | ☐ |
| Ulcers | ☐ | ☐ |
| **Hematology / Blood Disorder** | | |
| Anemia | ☐ | ☐ |
| Free Bleeder | ☐ | ☐ |
| **Genitourinary** | | |
| Bladder Infections | ☐ | ☐ |
| Blood in Urine | ☐ | ☐ |
| Incontinence | ☐ | ☐ |
| Kidney Stones | ☐ | ☐ |
| Trouble Starting/Stopping Stream of Urine | ☐ | ☐ |
| Prostate Cancer | ☐ | ☐ |
| UTI | ☐ | ☐ |
| Uterine/Cervical Cancer | ☐ | ☐ |

| | Current Problem | Past Problem |
|---|---|---|
| **Heart** | | |
| Last EKG __________ | ☐ | ☐ |
| Chest Pain | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ |
| Leg Pain when walking | ☐ | ☐ |
| **Musculoskeletal** | | |
| Muscle Ache | ☐ | ☐ |
| Weakness | ☐ | ☐ |
| Fatigue | ☐ | ☐ |
| Spasms | ☐ | ☐ |
| **Neurological** | | |
| Blackout spells | ☐ | ☐ |
| Seizures | ☐ | ☐ |
| Coordination Trouble | ☐ | ☐ |
| Double/Blurred Vision | ☐ | ☐ |
| Facial Weakness | ☐ | ☐ |
| Speech Difficulty | ☐ | ☐ |
| **Psychiatric** | | |
| Bipolar | ☐ | ☐ |
| Depression | ☐ | ☐ |
| Psychiatric Treatment | ☐ | ☐ |
| **Respiratory** | | |
| Last Chest X-ray __________ | | |
| Oxygen Use | ☐ | ☐ |
| CPAP Use | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Bronchitis | ☐ | ☐ |
| COPD | ☐ | ☐ |
| Emphysema | ☐ | ☐ |
| Lung Cancer | ☐ | ☐ |
| Pleurisy | ☐ | ☐ |
| Pneumonia | ☐ | ☐ |
| Shortness of Breath | ☐ | ☐ |
| **Skin / Integumentary** | | |
| Last Mammogram __________ | | |
| Breast Disorder | ☐ | ☐ |
| Easy Bruising | ☐ | ☐ |
| Skin Cancer | ☐ | ☐ |
| Skin Ulcers | ☐ | ☐ |
| Sores or Abscesses | ☐ | ☐ |
| Thin Skin | ☐ | ☐ |

**Any Other Types Cancer**

______________________________

**Any Types of Stents**

______________________________

The above information is accurate to the best of my knowledge.

**PATIENT SIGNATURE**: ______________________________ DATE: ______________

I have reviewed the information with the patient.

**PHYSICIAN SIGNATURE**: ______________________________ DATE: ______________