



Please answer the questions below concerning your health history. Be sure to list all conditions or symptoms, both past or present.

**An Understanding of your health history will help us to determine appropriate care.**

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_ Case#: \_\_\_\_\_  
Age: \_\_\_\_\_ Race: \_\_\_\_\_ Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

### Review of Systems

- Yes  No Do you have skin, hair or nail problems? \_\_\_\_\_
- Yes  No Do you have mouth and/or throat problems? \_\_\_\_\_
- Yes  No Do you have nose and/or sinus problems? \_\_\_\_\_
- Yes  No Do you have ear problems? \_\_\_\_\_
- Yes  No Do you have eye problems? \_\_\_\_\_
- Yes  No Do you have chest or lung (breathing) problems? \_\_\_\_\_
- Yes  No Do you smoke? Cigarettes per day: \_\_\_\_\_ How Long?: \_\_\_\_\_
- Yes  No Do you have heart and/or blood vessel problems? \_\_\_\_\_
- Yes  No Do you have blood or lymph node problems? \_\_\_\_\_
- Yes  No Do you have digestive problems? \_\_\_\_\_
- Yes  No Do you have genital problems (e.g., prostate, testicular, vaginal)? \_\_\_\_\_
- Yes  No Do you have urinary (including kidney or bladder) problems? \_\_\_\_\_
- Yes  No **Females:** have you had menstrual problems? \_\_\_\_\_
- Yes  No Have you ever taken birth control pills? \_\_\_\_\_
- Yes  No Is there any chance that you are currently pregnant? \_\_\_\_\_
- Yes  No Do you have any breast problems? \_\_\_\_\_
- Yes  No Do you have any nervous system diseases and/or mental health problems? \_\_\_\_\_
- Yes  No Do you have any gland and/or hormone problems? \_\_\_\_\_
- Yes  No Do you have allergy or immunity problems? \_\_\_\_\_
- Yes  No Do you have any muscle, tendon or ligament problems? \_\_\_\_\_
- Yes  No Do you have any bone or joint diseases (examples: bone = osteoporosis, joint = arthritis)? \_\_\_\_\_

### Past History

List any diseases that you have had in the past, including childhood diseases: \_\_\_\_\_

Tell us if you have ever been diagnosed as having a particular condition, such as diabetes, cancer, AIDS, etc.: \_\_\_\_\_

Yes  No

Have you suffered any physical injuries, such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones? \_\_\_\_\_

List any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth): \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_



Full Name: \_\_\_\_\_ Date: \_\_\_\_\_ Case#: \_\_\_\_\_

Yes  No Have you ever been hospitalized for any reason other than surgery? \_\_\_\_\_

Yes  No **Medications:** Please list all medications (prescription & non-prescription) you are currently taking or take on an occasional basis: \_\_\_\_\_

Your diet is:  Balanced  Fair  Poor  Excessive  Restricted

**Family History:** \_\_\_\_\_

Yes  No Are there any diseases or conditions that are common among family members (i.g., inherited diseases or conditions)? \_\_\_\_\_

**Special History:** \_\_\_\_\_

In what position do you usually sleep, and how well? \_\_\_\_\_

Yes  No Do you exercise on a regular basis? How? \_\_\_\_\_

How do you spend your spare time (hobbies, etc)? \_\_\_\_\_

Do you use:  Caffeine  Tobacco  Nicotine  Recreational Drugs  Alcohol

Please describe your work.

Type:  Professional  Physical Labor  Driver  Clerical  Factory  Homemaker

Physical Demands:  Heavy  Moderate  Mild  Sedentary

Stress Level:  High  Medium  Low

**Additional Questions:**

Yes  No Do you have problems with recurring headaches? \_\_\_\_\_

Yes  No Are you losing weight without trying? \_\_\_\_\_

Yes  No Does your pain wake you up at night? \_\_\_\_\_

Yes  No Have you had a change in bowel or bladder habits? \_\_\_\_\_

Yes  No Have you had a sore that doesn't heal? \_\_\_\_\_

Yes  No Have you recently had any unusual bleeding or discharge? \_\_\_\_\_

Yes  No Do you have a thickening/lump in the breast or elsewhere? \_\_\_\_\_

Yes  No Do you have indigestion or difficulty swallowing? \_\_\_\_\_

Yes  No Have you had an obvious change in a wart or mole? \_\_\_\_\_

Yes  No Do you have a nagging cough or hoarseness? \_\_\_\_\_

In the space below, please explain or give additional details regarding the information you have given above. Also if there is any information about your health history that was not requested, please fill it in below.

\_\_\_\_\_  
\_\_\_\_\_

Please describe your current complaint. In other words, what brought you here?

\_\_\_\_\_  
\_\_\_\_\_

**Who is your:**

Medical \_\_\_\_\_

OB/GYN? \_\_\_\_\_

Dentist? \_\_\_\_\_