

Health History

Please circle: C= Current condition/circumstance P= Past condition/circumstance

General:

Fatigue C P
Night sweats C P

Skin:

Rashes C P
Eczema, hives C P
Other: _____ C P

Head:

Headaches C P
Migraines C P
Hair loss C P
Head injury C P
Dizziness C P

Eyes:

Change in vision C P
Double vision C P
Eye pain C P
Tearing/Dryness C P
Glasses/Contacts C P

Ears:

Hard of hearing C P
Ringing C P
Earache C P

Nose/Sinuses:

Frequent colds C P
Stiffness C P
Sinus infections C P
Hay fever C P
Nose bleeds C P

Mouth & throat:

Sore Throat C P
Swollen Tongue C P
Difficulty swallowing C P

Neck:

Lumps C P
Pain or stiffness C P

Respiratory:

Asthma C P
Emphysema C P
Frequent cough C P
Bronchitis C P
Shortness of Breath C P
Wheezing C P
Pain on breathing C P
Pneumonia C P

Cardiovascular:

Heart failure C P
Heart attack C P
Chest pain/angina C P
High blood pressure C P
High cholesterol C P
Fluttering in chest C P
Heart murmur C P
Ankle Swelling C P

Gastrointestinal:

Frequent indigestion C P
Nausea C P
Vomiting C P
Abdominal pain C P
Liver disease C P
Heartburn C P
Ulcers C P
Hemorrhoids C P
Constipation C P
Diarrhea C P
Frequency Bowel movements?

_____ Is this a change? Y N

Urinary:

Pain on urination C P
Increased frequency C P
Dribble urine C P
Frequent infections C P
Kidney stones C P

Musculoskeletal:

Joint pain/stiffness C P
Arthritis C P
Broken bones C P
Osteoporosis C P
Muscle spasms C P
Muscle weakness C P
Loss of coordination C P
Sprains/Strains C P

Peripheral vascular:

Blood clots C P
Anemia C P
Bleeding/bruising C P
Varicose veins C P
Cold hands/feet C P
Raynauds disease C P

Cancer

C P
Type: _____
Stage: _____

Neurologic:

Head injury C P
When? _____
Stroke C P
Seizures C P
Fainting C P
Paralysis C P
Numbness/Tingling C P
Memory loss C P
Loss taste or smell C P
Loss of balance C P

Endocrine:

Hyperthyroid C P
Hypothyroid C P
Heat Intolerance C P
Cold Intolerance C P
Diabetes C P
Excessive Thirst C P

Emotional:

Depression/sadness C P
Anxiety C P
Mood swings C P
Anorexia C P
Bulimia C P

Male reproductive:

Hernias C P
Prostate disease C P
Sexually active C P
Sexually difficulties C P
Difficulty conceiving C P
STD's C P

Female reproductive:

Length of cycles _____
Regular cycles C P
Skipped cycle(s) C P
Breakthrough bleeding C P
Menopausal symptoms C P
Sexually active C P
Pain with intercourse C P
Birth control C P
What type? _____
Difficulty conceiving C P
STD's C P
Sexual difficulties C P
Vaginal infections C P
No. of pregnancies _____
No. of live births _____
No. of miscarriages _____
No. of abortions _____

NAME: _____

DATE of BIRTH: _____

HABITS:	Y	N	EXERCISE:	Y	N
Tobacco: How much/how often? _____ For how long have you smoked? _____			Exercise Routinely? What Forms? _____ How often? _____		
Alcohol: How much? _____ How often? _____			Do you enjoy it?		
Use Recreational Drugs?			WORK:		
Do you drink caffeinated products?			What Type? _____		
Do you drink 4-8 glasses of water daily?			Do you enjoy it?		
SLEEP:			Do you work unusual hours?		
Do you fall asleep easily?			LIVING SITUATION:		
Do you get between 6-8 hours of sleep each night?			With whom do you live? _____		
Awaken rested?			Do you enjoy where you live?		

PSYCHOLOGICAL/EMOTIONAL/SPIRITUAL LIFE:

What are your current stressors? _____

How do you manage stress? _____

History of depression/anxiety? _____

Hobbies: _____

Is a spiritual life important to you? If yes, please explain: _____

How would you describe your support system? _____

Family Health History: Immediate Family Only

✓	ILLNESS	Who?	✓	ILLNESS	Who?
	Cancer (type)			Asthma	
	Diabetes			Anemia	
	Heart Disease			Kidney Disease	
	High Blood Pressure			Glaucoma	
	High Cholesterol			Osteoporosis	
	Stroke			Tuberculosis	
	Epilepsy			Rheumatoid Arthritis	
	Mental Illness			Thyroid Disease	
	Autoimmune dis.				

NAME: _____

DATE of BIRTH: _____

YOUR MEDICAL HISTORY:

Height _____

Weight _____

✓	ILLNESS	When Diagnosed?	STABLE?	✓	ILLNESS	When Diagnosed?	STABLE?
	Cancer (type)				Asthma		
	Diabetes				Anemia		
	Heart Disease				Kidney Disease		
	High Blood Pressure				Glaucoma		
	High Cholesterol				Osteoporosis		
	Stroke				Tuberculosis		
	Epilepsy				Rheumatoid Arthritis		
	Mental Illness				Thyroid Disease		

CURRENT PRESCRIPTION DRUGS for ANY reason: *Drug & Dose*

Drug Name	Dose	How Often?

SUPPLEMENTS:

Allergies to Medications: _____

Allergies to Food, Environmental or Other Substances: _____

Trauma History:

Motor Vehicle Accidents? Y N When? _____, _____, _____

Concussions or Loss of Consciousness? Y N Age(s)? _____, _____, _____

Broken Bones? Y N Age(s): _____, _____, _____

Significant Falls? Y N Age(s): _____, _____, _____

Any other traumatic events that you believe impacted your health? _____

HOSPITALIZATIONS OR SURGERIES: *Please list reason/type of surgery and date.*

REASON/TYPE	DATE

NAME: _____

DATE of BIRTH: _____

CURRENT HEALTH CONCERNS

Reason(s) for Today's Visit? _____

How did symptoms start?

TIMING: When did symptoms start?

Circle: Are the symptoms constant or intermittent? Does the intensity of the symptoms fluctuate? Y / N

When during the day is your pain the worst? _____ When is it best? _____

QUALITY: Quality of pain: *Circle:* Burning, Stabbing, Aching, Throbbing, Dull, Sharp, Penetrating, Tiring, Tender, Nagging, Tingling, Miserable, Shooting, Stabbing, Intermittent, Gnawing, Exhausting, Numb, Unbearable

Severity of Pain NOW: *Circle* (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Highest level over the PAST 2 WEEKS: 0 1 2 3 4 5 6 7 8 9 10

Lowest level over the PAST 2 WEEKS: 0 1 2 3 4 5 6 7 8 9 10

What aggravates your pain? _____

What relieves your pain? _____

Medications that you've tried: e.g. – Opioids, Antidepressants, Muscle relaxants, Anti-inflammatories, etc.

NAME:	Did it help?	NAME:	Did it help?

What other **treatments / therapies** have you tried? e.g. – injections, massage, chiropractic, etc.

TYPE:	Did it help?	TYPE:	Did it help?

What **diagnostic imaging** have you had? e.g. - XRAY, MRI, CT SCAN or OTHER

STUDY	DATE	BODY PART	RESULT

