

CONFIDENTIAL HEALTH HISTORY

Today's Date _____

Dear Patient: This information is considered confidential. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Last: _____ First: _____ MI: _____

Height: _____ Weight: _____ Occupation: _____

Employment Status: FT PT Retired Employer: _____

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Please describe the principal health problems for which you came to this office:

Date you first noticed symptoms: _____ How long do the symptoms last? _____

Is this condition getting progressively worse? Yes No Constant Comes and goes

Is this condition interfering with your: Work Sleep Daily Routine Other _____

List any treating physicians: _____

List any diagnosis(s) and type of treatment(s)

Have you lost any days of work? Yes No How Many? _____

Have you had similar accident or injuries before? Yes No If yes, explain: _____

Have you been treated for any health conditions by a physician in the last year? Yes No

If yes, explain _____

Are you currently under medication? Yes No If yes, what kind?

List any surgeries, serious accidents, unusual diseases, or hospitalizations:

Rate Pain Level (0) is no pain, (10) is worst possible pain

Typical Day 0 1 2 3 4 5 6 7 8 9 10

Worst pain in last week 0 1 2 3 4 5 6 7 8 9 10

Best pain has been in last week 0 1 2 3 4 5 6 7 8 9 10

What makes your pain better? _____

Please circle the location of your pain



What makes your pain worse? _____

Directions: Please circle the appropriate line for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we treat you. If you have difficulty, please ask the receptionist.

MUSCULOSKELETAL

low back pain, stiffness
neck pain, stiffness
pain in shoulders
pain between shoulders
pain in arms
pain in elbows
pain in hands, wrists, fingers
pain in hips
pain in legs
pain in knees
pain in feet
difficulty walking
painful tailbone
swollen joints
joint stiffness
muscle cramps
arch supports
uncomfortable mattress
firm mattress
regular bed
waterbed
arthritis

NERVOUS

headaches, any relatives?
profuse sweating
nervousness, depression
weakness
dizziness
fatigue
irritable
mentally sluggish/forgetful
sciatica
loss of balance
fainting
loss of taste
loss of smell
paralysis

EYE, EAR NOSE & THROAT

earache
ear noises
corrective lenses
light bothers eyes
nose bleeds
sinus problems
sore throats
hoarseness
tonsillitis
difficulty swallowing
cold sores

CARDIOVASCULAR/RESPIRATORY

chest pain
chronic cough
difficulty breathing
pacemaker
swelling of ankles
high blood pressure, any relatives?
poor circulation
lung problems
hands/feet cold
consume tobacco ____ packs/day
anemia
heart disease, any relatives?
paralytic stroke, any relatives?
Varicose veins

FEMALE

lumps in breast
menstrual irregularity
menstrual cramps
miscarriage
menopausal symptoms
hot flashes

GENITOURINARY

frequent urination
painful urination
Inability to control urine

MISCELLANEOUS

boils
chills
drug reaction - which

dry skin
eczema
fever
hemorrhoids
influenza
bruise easily
weight loss
knocked unconscious
hospitalized
difficulty sleeping
exercise

GASTROINTESTINAL

abdominal swelling
diarrhea
hernia
liver
ulcers
vomiting/nausea
constipation
indigestion
consume alcohol
consume drugs
consume coffee ____ cups/day
consume vitamins/minerals?

OTHER CONDITIONS

polio
alcoholism
alcohol use ____ drinks/week
recreational drug use
bleeding
hearing disorder
thyroid problems
herpes
multiple sclerosis
seizures
emphysema
mental disorder
tuberculosis
asthma
A.I.D.S.
gout
malaria
measles
rheumatic fever
scarlet fever
small pox
typhoid fever
cancer, any relatives?
diabetes, any relatives?
kidney stones, any relatives?
prostate problems
venereal disease
appendicitis
gall bladder problems
allergies - which _____



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