

## Patient Health History

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

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: M F Marital Status: \_\_\_\_\_

Social Security: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_ Relationship: \_\_\_\_\_

1. Are you currently receiving health care? Y N From whom: \_\_\_\_\_

2. Has your case been referring to an attorney? Y N

3. Please identify the health concerns that have brought you to the clinic today:

Condition Past Treatment

a. \_\_\_\_\_

b. \_\_\_\_\_

c. \_\_\_\_\_

d. \_\_\_\_\_

4. Do you have any reason to believe you are pregnant? Y N

5. Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Max Weight: \_\_\_\_\_ When: \_\_\_\_\_

6. **Childhood Illness** (please circle any you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles Chicken Pox

7. **Immunizations** (please circle any you have had):

Polio Tetanus Measles/Mumps/Rubella Pertussis Diphtheria Hepatitis B

Other

8. Do you have any chronic infectious diseases? Y N

If yes, please explain: \_\_\_\_\_

9. Are you currently suffering from any chronic illness? Y N

If yes, please explain: \_\_\_\_\_

10. **Severe Illnesses:** \_\_\_\_\_

11. **Please list all allergens, foods, drugs, and medications you are hypersensitive or allergic to and the type of reaction:** \_\_\_\_\_

\_\_\_\_\_

12. **Please list all prescription medications you are currently taking:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

13. **Please list all over-the-counter medications, vitamins, and supplements that you are currently taking:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

14. **Hospitalizations and surgeries:**  
Reason                      When                      Reason                      When

\_\_\_\_\_

\_\_\_\_\_

15. **X-Rays/CAT Scans/MRI's/Special studies:**  
Reason                      When                      Reason                      When

\_\_\_\_\_

\_\_\_\_\_

| 16. <b>Family History:</b>                         | <u>Mother</u> | <u>Father</u> | <u>Siblings</u> | <u>Spouse</u> | <u>Children</u> |
|--|---------------|---------------|-----------------|---------------|-----------------|
| Deceased (Y/N)                                     | _____         | _____         | _____           | _____         | _____           |
| Cause of death                                     | _____         | _____         | _____           | _____         | _____           |
| Age  | _____         | _____         | _____           | _____         | _____           |
| Health (G=good, P=Poor)                            | _____         | _____         | _____           | _____         | _____           |
| Check any conditions that family members have had: |               |               |                 |               |                 |
| Cancer   | _____         | _____         | _____           | _____         | _____           |
| Diabetes   | _____         | _____         | _____           | _____         | _____           |
| Heart Disease                                      | _____         | _____         | _____           | _____         | _____           |
| High Blood Pressure                                | _____         | _____         | _____           | _____         | _____           |
| Stroke   | _____         | _____         | _____           | _____         | _____           |
| Mental Illness                                     | _____         | _____         | _____           | _____         | _____           |

**Please CIRCLE current, UNDERLINE past experiences**

17. **Emotional**  
Mood Swings                      Nervousness                      Mental Tension
18. **Energy and Immunity**  
Fatigue/Chronic Fatigue Syndrome                      Slow Wound Healing                      Chronic Infections
19. **Head, Eye, Ear, Nose, Throat**  
Impaired Vision              Eye Pain/Strain              Glaucoma              Glasses/Contacts              Tearing/Dryness  
Impaired Hearing              Ear Ringing              Earaches              Headaches              Sinus Problems  
Nose Bleeds              Teeth Grinding              Frequent Sore Throats              TMJ/Jaw Problems  
Hay Fever
20. **Respiratory**  
Pneumonia              Frequent Common Colds              Difficulty Breathing              Emphysema  
Persistent Cough              Pleurisy                                      Asthma                                      Tuberculosis  
Shortness of Breath      Other:
21. **Cardiovascular**  
Heart Disease              Chest Pain                      Swelling of ankles                      High Blood Pressure  
Palpitations              Stroke                                      Heart Murmurs                                      Rheumatic Fever  
Varicose Veins
22. **Gastrointestinal**  
Ulcers              Changes in Appetite                      Nausea/Vomiting                      Epigastric Pain  
Heartburn              Belching                                      Liver Disease                                      Hepatitis B or C  
Hemorrhoids      Abdominal Pain
23. **Stool**  
Diarrhea              Constipation                                      Undigested Food                                      Mucous or Blood in stool
24. **Genito-Urinary Tract**  
Kidney Disease              Painful Urination                      Frequent Urinary Tract Infections  
Frequent Urination              Venereal Disease                      Kidney Stones Impaired Urination                      Urination at night  
Blood in Urine

25. **Female Reproduction**  
 Irregular cycles      Breast lumps/tenderness      Nipple Discharge      Heavy Flow  
 Clotting      Bleeding between Cycles      Bleeding between Cycles      Vaginal Discharge  
 Premenstrual Problems      Menopausal Symptoms      Post Menopause  
 Difficulty Conceiving      Pain with Intercourse
26. **Menstrual/Birthing History**  
 Age of First Menses: \_\_\_\_\_ #of Days of Menses: \_\_\_\_\_ Length of Cycle: \_\_\_\_\_  
 Birth Control Now: \_\_\_\_\_ Birth Control Use in the Past: \_\_\_\_\_  
 # of Pregnancies: \_\_\_\_\_ # of Miscarriages: \_\_\_\_\_ # of Abortions: \_\_\_\_\_ # of Live Births: \_\_\_\_\_  
 Are You Fertile? Y N      Age at Menopause \_\_\_\_\_ Vaginal Discharge
27. **Male Reproductive**  
 Sexual Difficulties      Prostrate Problems      Testicular Pain/Swelling      Penile Discharge  
 Pain with Intercourse
28. **Musculoskeletal**  
 Neck/Shoulder Pain      Muscle Spasms/Cramps      Arm Pain      Upper Back Pain      Mid Back Pain  
 Low Back Pain      Leg Pain      Joint Pain      Where: \_\_\_\_\_
29. **Neurologic**  
 Vertigo/Dizziness      Paralysis      Numbness/Tingling      Loss of Balance      Seizures/Epilepsy
30. **Endocrine**  
*Hypothyroid*      *Hyperthyroid*      *Hypoglycemia*      Diabetes Mellitus      Night Sweats  
 Feeling Hot or Cold      Hot Flashes
31. **Other**  
 Anemia      Cancer      Rashes Eczema/Hives      Cold Hands/Feet
32. **Lifestyle**  
 A. **Typical Food Intake**  
 Breakfast: \_\_\_\_\_  
 Lunch: \_\_\_\_\_  
 Dinner: \_\_\_\_\_  
 Snacks: \_\_\_\_\_  
 B. **Exercise:** \_\_\_\_\_

- C. **When do you go to sleep?** \_\_\_\_\_ **When do you awake?** \_\_\_\_\_
- D. **Education Level:** \_\_\_\_\_
- E. **Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_
- Hours/week: \_\_\_\_\_
- Do you enjoy work? Y      N      Why/Not? \_\_\_\_\_
- F. **Nicotine/Alcohol/Caffeine/Recreational drug use:** \_\_\_\_\_
- How Often? \_\_\_\_\_
- G. **Have you experienced any major traumas (emotional, spiritual, physical):**    Y      N
- Please explain: \_\_\_\_\_
- H. **Consumption of Liquids**
- Type of fluid: \_\_\_\_\_ Amount per day: \_\_\_\_\_
- I. **Television Habits:** \_\_\_\_\_
- J. **Reading Habits:** \_\_\_\_\_
- K. **Interests and Hobbies:** \_\_\_\_\_