Health History Form

Referring Physician: ________________________________ City______________________ State______

Primary Care Physician: ______________________________ City______________________ State______

May we send your physician(s) a report of this visit? ☐ Yes ☐ No

Your Current Problem:

Please describe the problem that brings you into the office today: ________________________________

____

Describe the symptoms and area affected (type of pain, swelling, numbness, etc.) ______________________

____

When did the problem begin (date of injury)? ____

If you had and injury, how did it happen? ____

____

Is this a work related problem? ☐ Yes ☐ No If disabled, when did you work last? _________________

Is there an attorney involved with your case? ☐ Yes ☐ No If yes, whom: _________________________

Social History

How do you evaluate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What is your work status? ☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student ☐ Homemaker

What is your occupation? ____

What level of activity is required in your workplace?

☐ Mild-desk job ☐ Moderate-standing, lifting ☐ Extensive-manual labor

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

Do you have any children? ☐ Yes ☐ No If so, how many children? ______________________________

Who lives at home with you? ____

Health History

Do you use tobacco? ☐ Yes ☐ No Did you previous use tobacco? ☐ Yes ☐ No

☐ Cigarettes________pack/day ☐ Pipe ☐ Cigar ☐ Chewing tobacco ☐ E-cigarettes

For how many years? __________________________

Do you use alcohol? ☐ Yes ☐ No If yes, number of drinks _______Daily ______ Weekly _______ Monthly

Do you use any street drugs? ☐ Yes ☐ No If yes, describe: ____

Do you have a history of drug/alcohol abuse? ☐ Yes ☐ No If yes, describe: ____________________________

Do you exercise regularly? ☐ Yes ☐ No If yes, how many times per week?___________________________

Do you follow a special diet? ☐ Yes ☐ No What kind? ____

Past Medical History

Please check the boxes of any past medical problems that you have/had.

- ☐ Diabetes
- ☐ Lung Disease
- ☐ Tuberculosis (TB)
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Ulcers
- ☐ Gastric Reflux/GERD
- ☐ Liver Disease
- ☐ Hepatitis A/B/C
- ☐ Alcoholism
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Stroke
- ☐ Blood Clots (DVT)
- ☐ Bleeding Tendencies
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Peripheral Vascular Disease
- ☐ Kidney Disease
- ☐ Depression
- ☐ Cancer
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Osteomyelitis
- ☐ Fractures
- ☐ Thyroid Disease
- ☐ Immune Disorder
- ☐ Seizure Disorder
- ☐ Multiple Sclerosis
- ☐ Polio
- ☐ Mental Illness
- ☐ None
- ☐ Other: ________________

Past Surgical History

Please list all of the operations that you have had in your lifetime.

Year	Type of Operation

Do you or a family member have any problems with anesthesia? ☐ Yes ☐ No If yes, describe: _____________

____

Medications

Please list all medications including over the counter medicines, herbals & prescription medications that you take.

Current Medicine	Dose	Frequency	Current Medicine	Dose	Frequency

Preferred local pharmacy: ______________________________

Allergies

Please list all medications and substances that you are allergic to.

Medication Allergy	What reaction did you have?
☐ None	
☐ Penicillin	
☐ Sulfa	
☐ Iodine	
☐ Latex	
☐ Contrast Dyes	
☐ Adhesive tape	
☐ Other (please specify)	
☐ Food Allergies	

Family History

Please check illnesses that have occurred in any of your blood relatives.

	Mother	Father	Sister	Brother	Mat. Grand Mother	Mat. Grand Father	Pat. Grand Mother	Pat. Grand Father
Alcoholism								
Arthritis								
Asthma								
Bleeding Tendencies								
Blood Clots								
Cancer								
Coronary Artery Disease								
Depression								
Diabetes								
Gastrointestinal Disease								
Heart Attack								
Heart Disease								
Hepatitis A/B/C								
High Blood Pressure								
Kidney Disease								
Lung Disease								
Mental Illness								
Osteoporosis								
Other								
Peripheral Vascular Disease								
Seizure Disorders								
Stroke								
Thyroid Disease								
Tuberculosis (TB)								
Ulcers								
Other:								

Relation	Alive	Deceased	Age	Health Status/Cause of Death
Mother				
Father				
Brother(s)				
Sister(s)				

Review of Systems/Current Symptoms:

Are you currently having or have you recently had any of the following problems?

Constitutional

Recent weight loss ☐ Yes ☐ No
Recent fevers or chills ☐ Yes ☐ No
Night sweats ☐ Yes ☐ No
Difficulty sleeping ☐ Yes ☐ No

Ears, Nose Throat

Hearing Loss ☐ Yes ☐ No
Ringing in ears ☐ Yes ☐ No
Sinus problems ☐ Yes ☐ No
Sore Throat ☐ Yes ☐ No
Active dental issue ☐ Yes ☐ No
Wear hearing aid ☐ Yes ☐ No
Wear dentures ☐ Yes ☐ No

Cardiovascular

Irregular heart beat ☐ Yes ☐ No
Chest pain, angina ☐ Yes ☐ No
Bleeding problems ☐ Yes ☐ No
Blood Clots ☐ Yes ☐ No
Swelling in arms or legs ☐ Yes ☐ No

Respiratory

Shortness of Breath ☐ Yes ☐ No
Cough ☐ Yes ☐ No
Breathing difficulties ☐ Yes ☐ No

Gastrointestinal

Heartburn ☐ Yes ☐ No
Nausea and/or Vomiting ☐ Yes ☐ No
Changes in bowel habits ☐ Yes ☐ No
Blood in bowel movements ☐ Yes ☐ No

Musculoskeletal

Joint pain ☐ Yes ☐ No
Limb pain ☐ Yes ☐ No
Muscle weakness ☐ Yes ☐ No
Difficulty moving arm/leg ☐ Yes ☐ No
Swelling limb/joint ☐ Yes ☐ No

Eyes

Wear glasses ☐ Yes ☐ No
Wear contacts ☐ Yes ☐ No
Cataracts ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Vision problems ☐ Yes ☐ No

Skin

Psoriasis or Eczema ☐ Yes ☐ No
Open sores or cuts ☐ Yes ☐ No
Dermatitis-rash ☐ Yes ☐ No
Active dental issue ☐ Yes ☐ No

Neurologic

Headaches ☐ Yes ☐ No
Dizziness ☐ Yes ☐ No
Falls ☐ Yes ☐ No
Memory Problems ☐ Yes ☐ No
Balance Problems ☐ Yes ☐ No
Numbness/Tingling ☐ Yes ☐ No

Endocrine

Diabetes ☐ Yes ☐ No
Thyroid Disorder ☐ Yes ☐ No

Cancer ☐ Yes ☐ No

What kind: __________________________

Genitourinary

Frequent bladder infections ☐ Yes ☐ No
Painful urination ☐ Yes ☐ No
Difficulty starting urination ☐ Yes ☐ No
Blood in urine ☐ Yes ☐ No

Mental Health

Depression ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No

Other

List: ________________________________

Patient signature: ____ Date: ____________________

Reviewed by: ________________________________ Date: ________________ Time: __________