

Have you ever been in an automobile accident? Yes No If yes, explain: _____

Have you ever had any major illnesses, injuries or falls? Yes No If yes, explain: _____

Have you ever had any surgeries? Yes No If yes, explain: _____

Are you currently or have you been taking any over the counter medications/vitamins/or prescription drugs on a regular basis? Yes No If yes, please list: _____

SOCIAL HEALTH HISTORY

- Do you smoke? Yes No Packs per day _____
Do you consume caffeine? Yes No Daily amount _____
Do you consume alcohol? Yes No Glasses per week? _____
Do you exercise? Yes No Hours per week? _____

FAMILY HEALTH HISTORY – health status (if deceased please state the cause.)

Mother: _____ Father: _____
Sisters: _____ Brothers: _____
Children: _____

MARK ANY OF THE FOLLOWING DISEASES YOU HAVE/HAD:

- Pneumonia Mumps Influenza Anemia Rheumatic Fever Small Pox Heart disease
 Pleurisy Polio Lumbago Diabetes Whooping Cough Measles Tuberculosis
 Eczema Arthritis Cancer Epilepsy Mental disorders HIV Chicken Pox
 Thyroid disorders

MARK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

<p><u>Musculoskeletal</u></p> <p><input type="checkbox"/> Low back pain <input type="checkbox"/> Pain between shoulders <input type="checkbox"/> Arm pain <input type="checkbox"/> Neck pain <input type="checkbox"/> Joint pain/stiffness <input type="checkbox"/> Walking problems <input type="checkbox"/> Difficulty chewing/jaw clicking</p> <p><u>C-V-R</u></p> <p><input type="checkbox"/> Chest pain <input type="checkbox"/> Short breath <input type="checkbox"/> Blood pressure problems <input type="checkbox"/> Irregular heartbeat <input type="checkbox"/> Heart problems <input type="checkbox"/> Lung Problems <input type="checkbox"/> Congestion <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Ankle Swelling <input type="checkbox"/> Stroke</p>	<p><u>Nervous System</u></p> <p><input type="checkbox"/> Nervousness <input type="checkbox"/> Paralysis <input type="checkbox"/> Dizziness <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Confusion/depression <input type="checkbox"/> Fainting <input type="checkbox"/> Convulsions <input type="checkbox"/> Cold/tingling limbs <input type="checkbox"/> Stress <input type="checkbox"/> Numbness</p> <p><u>EENT</u></p> <p><input type="checkbox"/> Vision problems <input type="checkbox"/> Dental problems <input type="checkbox"/> Sore throat <input type="checkbox"/> Ear aches <input type="checkbox"/> Hearing difficulty <input type="checkbox"/> Stuffed nose</p>	<p><u>Gastrointestinal</u></p> <p><input type="checkbox"/> Poor/excessive appetite <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Frequent nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Liver problems <input type="checkbox"/> Gall bladder problems <input type="checkbox"/> Weight trouble <input type="checkbox"/> Abdominal cramps <input type="checkbox"/> Gas/bloating after meals <input type="checkbox"/> Heartburn <input type="checkbox"/> Black/bloody stool <input type="checkbox"/> Colitis</p> <p><u>Genito-urinary</u></p> <p><input type="checkbox"/> Bladder trouble <input type="checkbox"/> Painful urination <input type="checkbox"/> Excessive urination <input type="checkbox"/> Discolored urine</p>	<p><u>General</u></p> <p><input type="checkbox"/> Fatigue <input type="checkbox"/> Allergies <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Fever <input type="checkbox"/> Headaches</p> <p><u>Male/Female Systems</u></p> <p><input type="checkbox"/> Menstrual irregularity <input type="checkbox"/> Menstrual cramps <input type="checkbox"/> Vaginal pain/infection <input type="checkbox"/> Breast pain/lumps <input type="checkbox"/> Prostate problems <input type="checkbox"/> Sexual dysfunction</p> <p><u>Females Only</u></p> <p>When was your last period? _____ Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure</p>
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Doctor's Notes: _____

Patient or guardian signature: _____ Date: _____

Doctor signature: _____ Date: _____