

# HEALTH HISTORY

Name \_\_\_\_\_

Date \_\_\_\_\_

What treatment have you already received for your condition? Medications \_\_\_\_\_ Surgery \_\_\_\_\_ Chiropractic \_\_\_\_\_ Physical Therapy \_\_\_\_\_ None  
Other \_\_\_\_\_

Name of other doctor (s) who have treated you for your condition \_\_\_\_\_

Date of last: **Physical Exam** \_\_\_\_\_ X-rays \_\_\_\_\_ Blood Test \_\_\_\_\_  
MRI, CT-Scan, Bone Scan \_\_\_\_\_ Urine Test \_\_\_\_\_

Place a circle on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Yes	No	Diabetes	Yes	No	Mononucleosis	Yes	No	Rheumatoid		
Alcoholism	Yes	No	Emphysema	Yes	No	Multiple			Arthritis	Yes	No
Allergy Shots	Yes	No	Epilepsy	Yes	No	Sclerosis	Yes	No	Rheumatic		
Anemia	Yes	No	Fractures	Yes	No	Mumps	Yes	No	Fever	Yes	No
Anorexia	Yes	No	Glaucoma	Yes	No	Osteoporosis	Yes	No	Scoliosis	Yes	No
Appendicitis	Yes	No	Goiter	Yes	No	Pacemaker	Yes	No	Stroke	Yes	No
Arthritis	Yes	No	Gout	Yes	No	Parkinson's			Thyroid		
Asthma	Yes	No	Heart Disease	Yes	No	Disease	Yes	No	Problem	Yes	No
Bleeding Disorders	Yes	No	Hepatitis	Yes	No	Pinched Nerve	Yes	No	Tuberculosis	Yes	No
Breast Lump	Yes	No	Hernia	Yes	No	Pneumonia	Yes	No	Tumors,	Yes	No
Bronchitis	Yes	No	Herniated Disk	Yes	No	Polio	Yes	No	Growth's		
Cancer	Yes	No	High Cholesterol	Yes	No	Prostate Problem	Yes	No	Typhoid Fever	Yes	No
Cataracts	Yes	No	Kidney Disease	Yes	No	Prosthesis	Yes	No	Ulcers	Yes	No
Chemical Dependency	Yes	No	Liver Disease	Yes	No	Psychiatric Care	Yes	No	Whooping Cough	Yes	No
Chicken Pox	Yes	No	Measles	Yes	No	PMS	Yes	No			
			Migraine								
			Headache	Yes	No						

Other \_\_\_\_\_

\***Family Health History** (Who in your family has any disease or health problems?) Grandparents \_\_\_\_\_

Parents \_\_\_\_\_ Siblings \_\_\_\_\_

<p style="text-align: center;"><b>EXERCISE</b></p> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily	<p style="text-align: center;"><b>WORK ACTIVITY</b></p> <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	<p style="text-align: center;"><b>HABITS</b></p> <input type="checkbox"/> Smoking Packs/Day _____ <input type="checkbox"/> Alcohol Drinks/Week _____ <input type="checkbox"/> Coffee/Caffeine Cups/Day _____ <input type="checkbox"/> High Stress Level Reason _____
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Are you pregnant? Yes No Due Date \_\_\_\_\_ Do you have children? Yes No How Many? \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone _____	_____	_____