

# Health History Form

What is your height?

What is your weight?

Patient Name:

Birth Date:

Appt Date:

Rendering Provider:

Gender:

MRN:

Hand Preference

R  L  B

Staff to complete

BP

BMI

## Injury / Illness Information

Chief Complaint:

How long have you had this problem?  How did symptoms start?  suddenly  gradually  chronic

Have you experienced similar problems in the past?  No  Yes Related to  auto  work

If injury related, date of injury (mm/dd/yyyy):  /  /   other

## REFERRING PHYSICIAN

## PRIMARY PHYSICIAN

Referring Physician

Primary Physician

Please check and include last date of treatment for any of the following (mm/yyyy)  None

	mm/yyyy	Back	Neck	Brain
<input type="checkbox"/> MRI	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> CT	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Myelogram	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> X-Rays	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Discogram	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Epidural Injection	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	

	mm/yyyy	Upper Extremity	Lower Extremity
<input type="checkbox"/> EMG	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name of facility?			
<input type="checkbox"/> Physical Therapy	<input type="text"/>		
<input type="checkbox"/> Chiropractic	<input type="text"/>		
<input type="checkbox"/> Traction	<input type="text"/>		
<input type="checkbox"/> Pain Clinic	<input type="text"/>		

## PAST SURGICAL HISTORY (list any surgery you have had with the approximate year (yyyy) None

<input type="checkbox"/> Back Surgery Surgical Procedure: <input type="text"/>	<input type="checkbox"/> Appendectomy <input type="text"/>	<input type="checkbox"/> Hysterectomy <input type="text"/>
<input type="checkbox"/> Back Surgery Surgical Procedure: <input type="text"/>	<input type="checkbox"/> Carpal Tunnel <input type="text"/>	<input type="checkbox"/> Thyroidectomy <input type="text"/>
<input type="checkbox"/> Neck Surgery Surgical Procedure: <input type="text"/>	<input type="checkbox"/> Cataract <input type="text"/>	<input type="checkbox"/> Mastectomy <input type="text"/>
<input type="checkbox"/> Brain Surgery Surgical Procedure: <input type="text"/>	<input type="checkbox"/> Colectomy <input type="text"/>	<input type="checkbox"/> Stent <input type="text"/>
<input type="checkbox"/> Other Surgical Procedure: <input type="text"/>	<input type="checkbox"/> Colostomy <input type="text"/>	<input type="checkbox"/> Pacemaker <input type="text"/>
	<input type="checkbox"/> Gall Bladder <input type="text"/>	<input type="checkbox"/> Heart Bypass <input type="text"/>
	<input type="checkbox"/> Gastric Bypass <input type="text"/>	<input type="checkbox"/> Knee Replacement <input type="text"/>
	<input type="checkbox"/> Hernia Repair <input type="text"/>	<input type="checkbox"/> Knee Surgery <input type="text"/>
	<input type="checkbox"/> Hip Replacement <input type="text"/>	<input type="checkbox"/> Shoulder Surgery <input type="text"/>

*Please continue on other side*

**MEDICAL HISTORY** Please put a check next to the disease below if you currently have, or have have been diagnosed with in the past

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Allergies (Seasonal)                        | <input type="checkbox"/> Crohn's Disease     | <input type="checkbox"/> Hypertension            | <input type="checkbox"/> Renal Disease    |
| <input type="checkbox"/> Angina                                      | <input type="checkbox"/> Depression          | <input type="checkbox"/> Irritable Bowel Disease | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Arthritis                                   | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Liver Disease           | <input type="checkbox"/> Stroke (CVA)     |
| <input type="checkbox"/> Asthma                                      | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Migraine Headaches      | <input type="checkbox"/> Substance Abuse  |
| <input type="checkbox"/> Atrial Fibrillation                         | <input type="checkbox"/> GERD                | <input type="checkbox"/> Myocardial Infarction   | <input type="checkbox"/> Thyroid Disease  |
| <input type="checkbox"/> Blood Clots                                 | <input type="checkbox"/> Hepatitis C         | <input type="checkbox"/> Osteoarthritis          | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> COPD  | <input type="checkbox"/> HIV                 | <input type="checkbox"/> Osteoporosis            | Other                                     |
| <input type="checkbox"/> Coronary Artery Disease                     | <input type="checkbox"/> Hyperlipidemia      | <input type="checkbox"/> Peptic Ulcer Disease    | <input type="text"/>                      |
| <input type="checkbox"/> Cancer Type of cancer: <input type="text"/> |  |  | Other                                     |
|  |  |  | <input type="text"/>                      |

**ALLERGIES**  **NONE**

Medications you are allergic to:

  
  
  
  


Other allergies (food, seasonal, etc.)

  


- Are you allergic to?
- |  |   |
|--|---|
| <input type="checkbox"/> Adhesive Tape | <input type="checkbox"/> Gadolinium/MRI Contrast?       |
| <input type="checkbox"/> Latex         | <input type="checkbox"/> CT Contrast/Kidney Dye/Iodine? |

**MEDICATIONS**  **NONE**  
 (List all medications you are currently taking including herbal and over-the-counter medications)

Medication	Dose	Frequency
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

**SOCIAL HISTORY**

- Married  
 Single  
 Divorced  
 Widowed  
 Partner
- Do you have children?  Yes  No
- Number of sons?
- Number of daughters?

**EMPLOYMENT INFORMATION**

- Current work status:
- Full Time  
 Part Time  
 Unemployed  
 Disabled  
 Retired  
 Self Employed
- Employer Name:
- Job Title:



**TOBACCO USE**

Uses tobacco:  Currently  
 Never  
 Formerly

Tobacco type:  
 Cigarettes  
 Chewing  
 Cigar  
 Pipe  
 Smokeless

Amount per day:  (packs, ounces, cigars, pipes, units,) per day

Number of years:

Are you exposed to second hand smoke?  Yes  No

**ALCOHOL/DRUG USE**

Do you drink alcohol daily?  Yes  No  Formerly

Frequency

Number of drinks per day:

*Have you ever?*

Sought treatment for alcohol abuse?  
 Used illegal drugs?  
 Had an addiction problem with narcotic pain medications?

**VACCINATION**

Have you received an influenza vaccination this year?

Yes  No Date:

If you are 65 years or older, have you received the pneumonia vaccination?

Yes  No

**FAMILY HISTORY** Please indicate if your mother, father or sibling has or had any of the following diseases or it was their cause of death (COD)

	Mother		Father		Sister(s)		Brother(s)	
	Now	COD	Now	COD	Now	COD	Now	COD
<input type="checkbox"/> Patient is adopted								
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysm/Brain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychological Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke (CVA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other family history

REVIEW OF SYSTEMS (Please check if you have had any of the following in the last 6 months)  NONE

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Fevers           | <input type="checkbox"/> Visual loss        | <input type="checkbox"/> Abdominal pain       |
| <input type="checkbox"/> Fatigue          | <input type="checkbox"/> Double vision      | <input type="checkbox"/> Urinary Frequency    |
| <input type="checkbox"/> Weight loss      | <input type="checkbox"/> Ringing in ears    | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Rash             | <input type="checkbox"/> Hearing loss       | <input type="checkbox"/> Urinary Retention    |
| <input type="checkbox"/> Hives            | <input type="checkbox"/> Trouble swallowing | <input type="checkbox"/> Muscle Weakness      |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Chest pain         | <input type="checkbox"/> Joint pain           |
| <input type="checkbox"/> Bruising         | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Joint swelling       |
| <input type="checkbox"/> Easy bleeding    | <input type="checkbox"/> Leg swelling       | <input type="checkbox"/> Dizziness            |
| <input type="checkbox"/> Swollen glands   | <input type="checkbox"/> Coughing           | <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> Tremors          | <input type="checkbox"/> Sleep apnea        | <input type="checkbox"/> Headaches            |
| <input type="checkbox"/> Hair loss        | <input type="checkbox"/> Short of breath    | <input type="checkbox"/> Depression           |
| <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Nausea             | <input type="checkbox"/> Anxiety              |
| <input type="checkbox"/> Blurry vision    | <input type="checkbox"/> Vomiting           | <input type="checkbox"/> Insomnia             |

**Other:**

Thank you for completing our patient information form