Health History Questionnaire

Please complete all blanks

Patient Name: _____ Date:____/_____/_____

DOB: _____ / _____ / _____ Age: _____ Weight: _____ pounds Height: ____'____"

Marital Status: □married □single □widowed □ divorced □separated

What is or was your occupation? _____

What is your work status? □full-time □part-time □military □retired □unemployed □disability

Date last worked: _____

What are your current symptoms?_____

_____

Approximate date your symptoms began? _____

Is this problem work related? □ No □Yes

If yes, date of injury: ____/____/_____

Were you injured in a car accident? □ No □Yes

If yes, date of accident: _____/_____/_____

Will you be involved in litigation due to this problem? □ No □Yes

Have you taken any steroid, Cortisone, or Prednisone in the last 12 months? □ No □Yes

Do you presently use tobacco? □ No □Yes If yes, type: □ cigarettes □cigars □dip/chew

Indicate amount or number of packs/day: _____

Have you ever previously used tobacco? □ No □Yes

If yes, for how many years?_____ Amount used:_____

When did you quit?_____

Do you drink alcoholic beverages? □ No □Yes

If yes, amount: _____ Frequency: □daily □weekly □monthly

Have you ever previously consumed alcohol? □No □Yes

If yes, when did you quit? _____

Do you use recreational drugs? □ No □Yes

If yes, what type: _____ Amount:_____

Frequency: □daily □weekly □monthly

Are you currently taking any of the following medications: (Please check those that apply)

□ Coumadin □ Plavix □ Aspirin □ BC/Goody Powder □ Celebrex

□Other blood thinners: _____

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Please list all current MEDICATIONS:

Medication Name	Dosage(mg/ml)	Frequency?	Reason for use?

Please list all current ALLERGIES: (medications, foods, soaps, dye, tape, latex, other)

Allergic to:	What kind of reaction?

MEDICAL HISTORY (Please check all that apply to you)

Heart Condition

___ heart attack
___ chest pain
___ heart failure
___ heart disease
___ heart murmur
___ rheumatic fever
___ swelling of ankles
___ irregular heartbeat
___ mitral valve prolapse
___ hyperlipidemia (high/elevated cholesterol)
___ hypertension (high blood pressure)
___ pacemaker
___ coronary stint

Neurological Condition

___ history of head trauma
___ epilepsy
___ dizzy spells
___ stroke
___ seizures
___ chronic headache
___ paralysis
___ muscle weakness

Musculoskeletal Condition

___ arthritis
___ osteoarthritis
___ osteoporosis
___ back problems
___ neck problems
___ numbness/tingling of arms
___ numbness/tingling of legs
___ loss of strength
___ fibromyalgia

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Blood Condition
___ anemia
___ bruise easily
___ bleeding/clotting problems
___ leukemia
___ sickle cell anemia
___ blood clot/deep vein thrombosis

Lung Condition
___ asthma
___ cystic fibrosis
___ emphysema
___ bronchitis
___ chronic cough
___ shortness of breath
___ sleep apnea

Other
___ diabetic
___ thyroid problems
___ glaucoma
___ hearing loss
___ attention deficit disorder
___ eye problems
___ ear, nose, throat problems
___ allergies
___ cancer (type)_____

Female
___ abnormal uterine bleeding
___ irregular periods
___ chronic yeast or vaginal infections

Male
____ enlarged prostate
____ difficult urination
____ erectile dysfunction

Stomach, Bowel & Liver Condition
___ hiatal hernia
___ inguinal hernia
___ bowel incontinence
___ ulcers
___ reflux
___ gallbladder disease
___ liver disease
___ colostomy

Urinary Condition
___ kidney stones
___ kidney failure
___ urinary incontinence
___ hemodialysis

Infectious Disease
___ hepatitis A B C (Please circle one)
___ tuberculosis
___ HIV
___ herpes
___ history of MRSA
___ history of staph infection

Psychiatric
___ anxiety
___ depression
___ bipolar disorder
___ other:_____

Have you been diagnosed with any other major health problem not listed above? □ No □ Yes

If yes, diagnosed condition: _____ year diagnosed: _____

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Have you had any recent or current fevers, chills or infections (bacterial or viral)? □ No □Yes

If yes, please describe: _____

Have you had any previous surgeries? □ No □Yes

If yes, please list below:

Type of Surgery	Doctor	Year

Has your immediate family (parent, sibling, grandparent) been diagnosed with any major medical conditions?

□ None □ I don't know □ Yes (please list below)

Condition / Disease	Family Member (father, sister, etc…)