

Health History Form

Today's Date: _____

Name: _____ **Age:** _____

Email Address: _____ **Marital Status:** _____ **#Children:** _____

DOB: _____ **Gender:** _____ **Social Security #:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **May we call you at home?** ___ **Message?** _____

Work Phone: _____ **May we call you at work?** ___ **Message?** _____

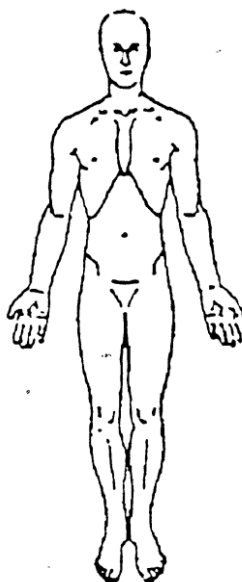
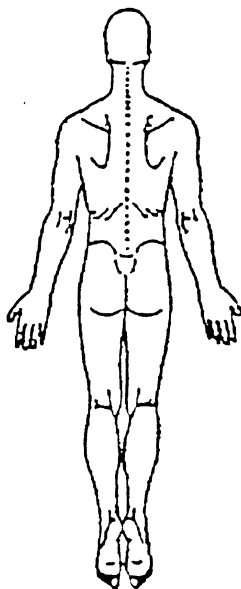
Occupation: _____

Medical Physician: _____ **Referred By:** _____

Primary Complaint:	Date of Onset:	Medications:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Please Mark On the Drawing:

- N - Numbness
- T - Tingling
- B - Burning
- St - Stabbing
- A - Achey
- So -- Sore
- Sh - Sharp
- D - Deep
- Sa - Shallow



Patient Surgeries:

1. **Date of Surgery:** _____ **Type of Surgery:** _____
Where: _____ **Complications of Surgery:** _____
2. **Date of Surgery:** _____ **Type of Surgery:** _____
Where: _____ **Complications of Surgery:** _____
3. **Other:** _____

Personal and Family History:

Self Family

- ___ ___ Allergies
- ___ ___ Arthritis
- ___ ___ Asthma
- ___ ___ Abdominal Pain
- ___ ___ Anorexia
- ___ ___ Aortic Aneurysm
- ___ ___ Blood Disorder
- ___ ___ Breast Soreness
- ___ ___ Bulimia
- ___ ___ Cancer
- ___ ___ Colitis
- ___ ___ Constipation
- ___ ___ Convulsions
- ___ ___ Diabetes
- ___ ___ Dislocated Joints
- ___ ___ Dizziness
- ___ ___ Emphysema

Self Family

- ___ ___ Epilepsy
- ___ ___ Fainting
- ___ ___ Headaches
- ___ ___ Migraines
- ___ ___ Heart Disease
- ___ ___ Rapid Heart Rate
- ___ ___ High Blood Pressure
- ___ ___ Low Blood Pressure
- ___ ___ Hemorrhoids
- ___ ___ Indigestion
- ___ ___ Irregular Menses/PMS
- ___ ___ Profuse Menses
- ___ ___ Irritable Colon
- ___ ___ Kidney Disease/Stones
- ___ ___ Liver Disease
- ___ ___ Lung Disease
- ___ ___ MS

Self Family

- ___ ___ Osteoporosis
- ___ ___ Polio
- ___ ___ Prostate Disease
- ___ ___ HIV/AIDS
- ___ ___ Stroke
- ___ ___ Sinus Trouble
- ___ ___ Scoliosis
- ___ ___ Sickle Cell Anemia
- ___ ___ Skin Problems
- ___ ___ Thyroid Disorder
- ___ ___ TB
- ___ ___ Ulcer
- ___ ___ Urinary Tract Infection
- ___ ___ Painful Urination
- ___ ___ Diarrhea
- ___ ___ Other _____
- ___ ___ Other _____

Please list any other conditions or concerns you would like the provider to know:

I understand that the information I have provided above is current and complete to the best of my knowledge:

Sign: _____ Date: _____