

CONFIDENTIAL HEALTH HISTORY

# GETTING TO KNOW YOU!

Patient: \_\_\_\_\_ Todays Date: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Occupation: \_\_\_\_\_ Injury/Onset Date: \_\_\_\_\_

## WHAT CONDITION / BODY PART (S) ARE YOU BEING SEEN FOR TODAY?

### PREVIOUS TREATMENT FOR THIS CONDITION

NO \_\_\_\_\_ YES \_\_\_\_\_

WHO (List physician or Health professional): \_\_\_\_\_

WHEN (Date treated) \_\_\_\_\_

WHERE (Office, Emergency Room, Hospital): \_\_\_\_\_

Check all Treatment received for this condition:

Anti-inflammatories \_\_\_\_\_  
 Pain medication \_\_\_\_\_  
 Muscle Relaxant \_\_\_\_\_  
 Injection \_\_\_\_\_  
 Surgery \_\_\_\_\_

X-rays \_\_\_\_\_  
 MRI \_\_\_\_\_  
 CT scan \_\_\_\_\_  
 Bone scan \_\_\_\_\_  
 EMG \_\_\_\_\_

Hospitalization \_\_\_\_\_  
 Casting/splint \_\_\_\_\_  
 Physical Therapy \_\_\_\_\_  
 Fracture put back  
 in place \_\_\_\_\_

### PAST MEDICAL HISTORY

Have you ever had	No	Yes	Year/Body Part
Anemia	_____	_____	_____
Angina	_____	_____	_____
Arthritis	_____	_____	_____
Asthma	_____	_____	_____
Bad Teeth	_____	_____	_____
Bladder infection	_____	_____	_____
Bleeding problems	_____	_____	_____
Blood clots	_____	_____	_____
Cancer	_____	_____	_____
Depression	_____	_____	_____
Diabetes	_____	_____	_____
Emphysema	_____	_____	_____
Epilepsy	_____	_____	_____

Have you ever had	No	Yes	Year/Body Part
Glaucoma	_____	_____	_____
Gout	_____	_____	_____
Heart Attack	_____	_____	_____
Heart Arrhythmia	_____	_____	_____
High Blood Pressure	_____	_____	_____
Kidney Disease	_____	_____	_____
Liver Disease/Hepatitis	_____	_____	_____
Psychiatric Treatment	_____	_____	_____
Stomach Ulcers	_____	_____	_____
Stroke	_____	_____	_____
Thyroid Disorders	_____	_____	_____
Tuberculosis	_____	_____	_____
OTHER	_____	_____	_____

### FAMILY HISTORY

Is there a family history of Arthritis, Heart Disease, Stroke, Diabetes or Cancer? No \_\_\_\_\_ Unknown \_\_\_\_\_ Yes \_\_\_\_\_ (Explain)

If "yes" please list condition and relative: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

## PATIENTS PREVIOUS SURGERIES

None: \_\_\_\_\_

(List procedure and date/year performed)

## ALLERGIES

None: \_\_\_\_\_

(List all known allergies)

## CURRENT MEDICATIONS

None: \_\_\_\_\_

(List all medications & dosage)

See attached list \_\_\_\_\_

## REVIEW OF SYSTEMS

Check all conditions and symptoms that you currently have.

GENERAL	<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Weight gain
EYES	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Double vision	<input type="checkbox"/> Poor vision	<input type="checkbox"/> Glasses
EARS / NOSE / THROAT	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Sinus congestion	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Sore throat
HEART	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Other
LUNGS	<input type="checkbox"/> Cough	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Other
INTESTINAL	<input type="checkbox"/> Upset stomach	<input type="checkbox"/> Bloody stools	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea
URINARY	<input type="checkbox"/> Burning	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Other
MUSCULOSKELETAL	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Joint Stiffness	<input type="checkbox"/> Other
SKIN	<input type="checkbox"/> Rashes	<input type="checkbox"/> Sores	<input type="checkbox"/> Masses	<input type="checkbox"/> Scars
NEUROLOGICAL	<input type="checkbox"/> Tremors	<input type="checkbox"/> Numbness	<input type="checkbox"/> Poor balance	<input type="checkbox"/> Dizziness
PSYCHIATRIC	<input type="checkbox"/> Depression	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Other
ENDOCRINE	<input type="checkbox"/> Hair loss	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Other
BLOOD/LYMPHATIC	<input type="checkbox"/> Leg swelling	<input type="checkbox"/> Bleeding tendency	<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Other
OB / GYN	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Birth Control Pills	<input type="checkbox"/> Hormone Therapy	<input type="checkbox"/> Menopausal

## SOCIAL HISTORY

Please answer each of the following:

Occupation: \_\_\_\_\_

How Many Years: \_\_\_\_\_

	No	Yes	How much
Caffeine	_____	_____	_____
Drugs	_____	_____	_____

	No	Yes	How often/much
Tobacco	_____	_____	_____
Alcohol	_____	_____	_____

I certify that the above information is correct to the best of my knowledge and will not hold my doctor or members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient signature: \_\_\_\_\_

Physician reviewed by: \_\_\_\_\_