

Personal Health History

Name _____

Date: _____

INJURIES & ACCIDENTS:

Type of Accident Date(s)
 Auto _____
 Work _____
 Fracture _____
 Dislocation _____
 Concussion _____
 Other _____

SURGERIES:

Type of Surgery
 Appendix Gall Bladder Hernia
 Hysterectomy Kidney Mastectomy
 Tonsils Other _____

ILLNESS:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Blindness	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Colitis	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Duodenal Ulcer	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Enlarged Heart	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Gallstones
<input type="checkbox"/> Gastritis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Goiter
<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Gout	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Hernia
<input type="checkbox"/> HIV	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Malaria
<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps
<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Nephritis	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Polio	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Syphilis	<input type="checkbox"/> Hyperthyroid	<input type="checkbox"/> Hypothyroid
<input type="checkbox"/> Low B.P.	<input type="checkbox"/> High B. P.	<input type="checkbox"/> High Triglycerides
<input type="checkbox"/> High Cholesterol		<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Rheumatic Fever		
<input type="checkbox"/> Other _____		
<input type="checkbox"/> Other _____		
<input type="checkbox"/> Other _____		

PSYCHIATRIC:

ALLERGIES:

<input type="checkbox"/> None	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Cats
<input type="checkbox"/> Foods	<input type="checkbox"/> Codeine	<input type="checkbox"/> Dust
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Pollen	
<input type="checkbox"/> Other _____		

HAVE YOU EVER BEEN DISABLED?

Yes No Date(s) _____

MEDICATION NOW TAKING:

MARITAL STATUS:

Single Married Separated
 Divorced Widowed

NUMBER OF CHILDREN: _____

EDUCATION:

Last grade level completed _____

FAMILY MEDICAL HISTORY:

Please identify illnesses within your immediate family

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Migraines	<input type="checkbox"/> Obesity
<input type="checkbox"/> Peptic Ulcer	<input type="checkbox"/> Renal Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Strokes	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Rheumatoid Arthritis

Additional: _____

HOBBIES:

GENERAL INFORMATION:

Height: Feet _____ Inches _____ Weight _____

Do you consider yourself...

<input type="checkbox"/> Alert	<input type="checkbox"/> Calm	<input type="checkbox"/> Nervous
<input type="checkbox"/> Irritable	<input type="checkbox"/> Depressed	<input type="checkbox"/> Fatigued
<input type="checkbox"/> Run Down		

Do you suffer from loss of sleep? Yes No

Do you smoke or use tobacco? Yes No

Do you drink alcoholic beverages? Yes No

Do you drink caffeinated beverages? Yes No

Do you consider yourself...

<input type="checkbox"/> Well Developed	<input type="checkbox"/> Average Developed
<input type="checkbox"/> Under Developed	<input type="checkbox"/> Well Nourished
<input type="checkbox"/> Average Nourished	<input type="checkbox"/> Under Nourished
<input type="checkbox"/> Large Build	<input type="checkbox"/> Medium Build
<input type="checkbox"/> Small Build	

WOMEN ONLY:

Are you pregnant at this time? Yes No

Date of last period _____

Date of last breast exam _____

Date of last pap smear _____

Do you experience...

<input type="checkbox"/> Menstrual pain	<input type="checkbox"/> Cramping	<input type="checkbox"/> Irregularity
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MEN ONLY:

Date of last prostate exam _____

PATIENT SIGNATURE

HISTORY OF SYMPTOMS

Name _____

Date _____

SYMPTOMS

HEAD:

- Headache
 - Entire head
 - Back of head
 - Forehead
 - Right temple
 - Left temple
 - Migraine
- Head feels heavy
- Loss of memory
- Light-headedness
- Fainting
- Light bother eyes
- Loss of balance
- Loss of smell
- Loss of taste
- Dizziness
- Loss of hearing
- Pain in ears
- Ringing in ears
- Buzzing in ears

NECK:

- Pain in neck
 - Neck pain is worse when I:
 - bend forward bend left
 - bend backward bend right
 - turn right turn left
- Sensation of a pinched nerve
- Neck feels out of place
- Neck feels stiff
- Muscle spasms in neck
- Grinding or grating sounds in neck
- Popping sounds in the neck
- Arthritis in the neck

SHOULDERS

- Pain in shoulder joint R L
- Pain across shoulders
- Bursitis R L
- Arthritis R L
- Can't raise arm:
 - above shoulder level
 - over head
- Tension in shoulders
- Pinched nerve in the shoulder R L
- Muscle spasms in shoulders

ARMS & HANDS

- Pain in upper arm R L
- Pain in forearm R L
- Pain in hand R L
- Pain in wrist R L
- Finger pain R L
- Pinched nerve in arm R L
- Pinched nerve in finger R L
- Sensation of pins and needles in arms R L
- Fingers go to sleep R L
- Hands feel cold R L
- Swollen joints in fingers R L

MID-BACK

- Mid-back pain
- Mid-back pain is worse when I:
 - bend forward
 - bend backward
 - bend right bend left
 - turn left turn right
- Pain between shoulder blades
- Sharp stabbing pain
- Muscle spasms

CHEST

- Chest pain
- Shortness of breath
- Pain around ribs
- Asthma
- Cough

ABDOMEN

- Nervous stomach
- Nausea
- Gas
- Constipation
- Diarrhea

LOW BACK

- Low back pain
- Low back pain is worse when I:
 - bend forward
 - bend backward
 - bend right bend left
 - twist left twist right
 - walk sit
 - stand lift
 - cough sneeze
 - stoop work
 - bowel movements
- Pinched nerve in low back
- Low back feels out of place
- Tailbone pain
- Tailbone pain is worse when I:
 - bend left bend right
 - twist left twist right
 - lift cough
 - sneeze stoop
 - work walk
 - bowel movements
- Muscle spasms low back
- Arthritis in low back

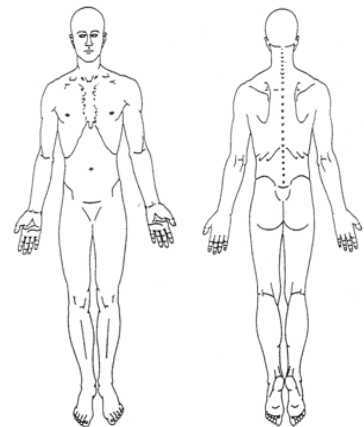
HIPS, LEGS & FEET

- Pain in buttocks R L
- Buttock pain is worse when I:
 - bend forward
 - bend backward
 - bend right bend left
 - twist left twist right
 - walk sit
 - stand lift

HIPS, LEGS & FEET CONT.

- cough sneeze
- stoop work
- bowel movements
- Pain in hip joints R L
- Hip joint pain is worse when I:
 - bend forward
 - bend backward
 - bend right bend left
 - twist left twist right
 - walk sit
 - stand lift
 - cough sneeze
 - stoop work
 - bowel movements
- Pain down legs R L
- Leg pain is worse when I:
 - bend forward
 - bend backward
 - bend right bend left
 - twist left twist right
 - walk sit
 - stand lift
 - cough sneeze
 - stoop work
 - bowel movements
- Leg cramps R L
- Sensation of pins and needles in legs R L
- Numbness in feet R L
- Numbness in legs R L
- Numbness in toes R L
- Feet feel cold R L
- Cramps in feet R L
- Swollen ankles R L
- Swollen feet R L
- Painful joints in toes R L

PLEASE MARK AN "X"
WHERE YOU FEEL PAIN,
TINGLING, OR
NUMBNESS.



Patient Signature