Health History Form

Name_____Age_____ Gender ☐ M or ☐ F
Height: _____Weight: _____Reason for appointment today: _____
Medications: (We will photo copy a list if one is available.)
_____
_____

Past Medical History

Diabetic	Y ☐ N ☐	Seizure Disorder	Y ☐ N ☐
Cardiac Conditions	Y ☐ N ☐	Osteoporosis	Y ☐ N ☐
Bleeding Disorder	Y ☐ N ☐	Asthma	Y ☐ N ☐
Kidney Disease	Y ☐ N ☐	Emphysema	Y ☐ N ☐
Liver Disease	Y ☐ N ☐	Anxiety Disorder	Y ☐ N ☐
Lung Disease	Y ☐ N ☐	Ulcer	Y ☐ N ☐
Stroke	Y ☐ N ☐	Peripheral Vascular Disease	Y ☐ N ☐
Rheumatoid Arthritis	Y ☐ N ☐	Pregnancies	Y ☐ N ☐
Cancer	Y ☐ N ☐	Depression	Y ☐ N ☐

If yes to any of the above, are you currently being treated? Please explain
_____
_____
_____

Are you currently experiencing any of the following?

Fever/Chills/Sweats	Y ☐ N ☐	Unexplained Weight Loss	Y ☐ N ☐
Changes in Vision	Y ☐ N ☐	Falls	Y ☐ N ☐
Numbness/tingling	Y ☐ N ☐	Ringing in Ears	Y ☐ N ☐
Change in Appetite	Y ☐ N ☐	Difficulty Swallowing	Y ☐ N ☐
Shortness of Breath	Y ☐ N ☐	Dizziness	Y ☐ N ☐
Headaches	Y ☐ N ☐	Nausea/Vomiting	Y ☐ N ☐
Depression	Y ☐ N ☐	Chest Pain	Y ☐ N ☐
Changes in Bowel/ Bladder Function	Y ☐ N ☐	Increased Pain at Night	Y ☐ N ☐

Other: _____
_____

Have you had any of the following for your present issue?

☐ X-ray ☐ MRI ☐ CT Scan

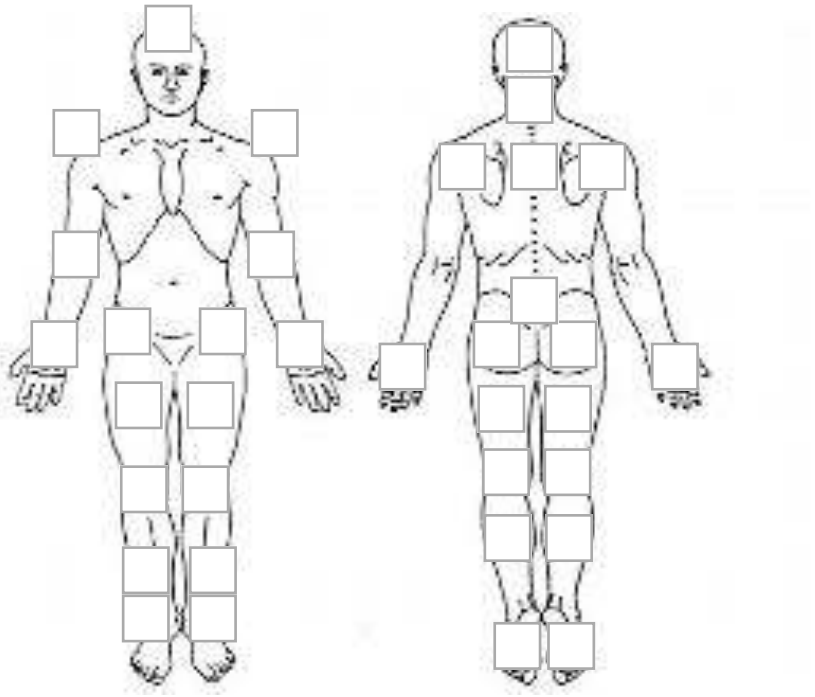
When: _____Where: _____

Have you had surgery for your present issue? Y ☐ N ☐

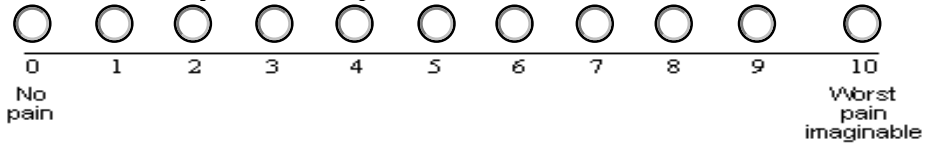
When: _____Where: _____

Health History Form

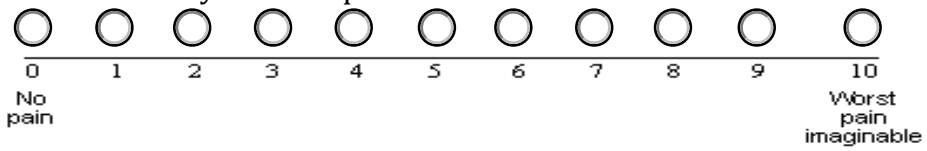
Please mark the body diagram with location of symptoms



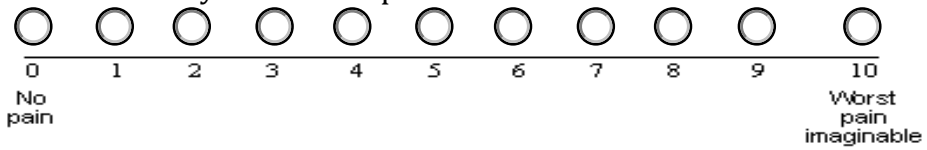
Please indicate your worst pain in last 48 hours



Please indicate your least pain in last 48 hours



Please indicate your current pain level



Consent: I understand that my diagnosis and treatment plan will be discussed during my appointment and I have the right to question/refuse any treatment offered.

Signature_____Date_____