## PERSONAL HISTORY

Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

S.S.#: _____ Email Address: _____

Birth Date: _____ Age: _____ Sex: M F Height: _____ Weight: _____

Check One: Married Single No. of Children: _____

Business/Employer: _____ Type of Work: _____

Referred To This Office By: _____

## CURRENT HEALTH CONDITION

Purpose of This Appointment: _____

Current Health Condition: _____

When did this condition begin? _____

Does this problem interfere with the following? Work Family Social Life Sports Hobbies

Other Doctor's Seen For This Condition: _____

Are there others in your family with this same condition? _____

Current Medication(s): Pain Relievers Anti-Inflammatory Muscle Relaxants Aspirin (similar)

Blood Pressure Insulin Thyroid Anti-Depressants Birth Control Other _____

## PAST HEALTH HISTORY

Major Surgery: Back Neck Heart Gall Bladder Hernia Cancer: _____

Major Accidents/Falls: _____

Hospitalizations (other than above): _____

Have You Been Treated For Any Health Condition In The Past Year? Yes No

If Yes, Please Explain: _____

PATIENT'S SIGNATURE _____ DATE _____

GUARDIAN'S SIGNATURE _____ DATE _____

**Please check off ANY of the following signs and symptoms apply. A complete history and understanding of your health status will facilitate care.**

**GENERAL SYMPTOMS**

- ☐ Headaches
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Loss of Sleep
- ☐ Fatigue
- ☐ Nervousness
- ☐ Loss of Weight
- ☐ Arm/Hand Numbness
- ☐ Arm/Hand Pain
- ☐ Leg/Foot Numbness
- ☐ Leg/Foot Pain
- ☐ Neuralgia

**GASTRO-INTESTINAL**

- ☐ Poor Appetite
- ☐ Poor Digestion
- ☐ Excessive Hunger
- ☐ Belching or Gas
- ☐ Nausea
- ☐ Vomiting
- ☐ Stomach Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Colon Trouble
- ☐ Hemorrhoids
- ☐ Liver Trouble
- ☐ Jaundice
- ☐ Gall Bladder Trouble

**EYE-EAR-NOSE-THROAT**

- ☐ Poor Vision
- ☐ Crossed Eyes
- ☐ Pain in Eyes
- ☐ Deafness
- ☐ Earache
- ☐ Ear Noises
- ☐ Ear Discharges
- ☐ Nasal Obstruction
- ☐ Nose Bleeds
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Asthma/Wheezing
- ☐ Frequent Colds
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Sinus Trouble

**RESPIRATORY**

- ☐ Chronic Cough
- ☐ Spitting Blood
- ☐ Spitting Phlegm
- ☐ Chest Pain
- ☐ Difficulty Breathing

**GENITO-URINARY**

- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Bed Wetting
- ☐ Urine Control Trouble
- ☐ Prostate Trouble

**MUSCLES & JOINTS**

- ☐ Weakness
- ☐ Twitching
- ☐ Stiff Neck
- ☐ Backache
- ☐ Swollen Joints
- ☐ Tremors
- ☐ Foot Troubles
- ☐ Painful Tailbone
- ☐ Mid/Upper Back Pain
- ☐ Hernia
- ☐ Spinal Curvature

**CARDIO-VASCULAR**

- ☐ Rapid Heart Beat
- ☐ Slow Heart Beat
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Pain Over Heart
- ☐ Prior Heart Condition
- ☐ Ankle Swelling
- ☐ Poor Circulation
- ☐ Varicose Veins
- ☐ Stroke History

**SKIN OR ALLERGIES**

- ☐ Skin Eruptions
- ☐ Itching
- ☐ Bruise Easily
- ☐ Dryness
- ☐ Boils
- ☐ Sensitive Skin
- ☐ Hives
- ☐ Allergies (What?)
- ☐ Eczema
- ☐ Medicines
- ☐ Hay Fever

**FOR WOMEN ONLY**

- ☐ Painful Periods
- ☐ Excessive Flow
- ☐ Irregular Cycles
- ☐ Hot Flashes
- ☐ Cramps or Backache
- ☐ Miscarriage
- ☐ Vaginal Discharge
- ☐ Pregnant At This Time
- ☐ Last PAP Smear

Date: _____

Doctor: _____

**FAMILY HISTORY**

| | Diabetes | Heart | Kidney | Cancer | Back |
|---|---|---|---|---|---|
| Mother | ☐ | ☐ | ☐ | ☐ | ☐ |
| Father | ☐ | ☐ | ☐ | ☐ | ☐ |
| Brother | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sister | ☐ | ☐ | ☐ | ☐ | ☐ |

**HABITS**

- ☐ Smoking __ Pks/Day
- ☐ Alcohol __ Drinks/Day
- ☐ Soft Drinks __ Cans/Day
- ☐ Coffee __ Cups/Day
- ☐ Chocolate __ Ounces/Day

**EXERCISE**

- ☐ None
- ☐ Moderate
- ☐ Daily

_____

(Types of Exercise)

I have completed this form completely and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I may have some type of insurance coverage I am responsible for payment of services. The policy in this office is the parent who requests treatment for the child is responsible for all fees for services rendered.

PATIENT'S SIGNATURE _____ DATE _____

GUARDIAN'S SIGNATURE _____ DATE _____