

Health History

Name:

Chart #:

Today's Date:

Date of Onset:

Please select all choices that apply to the patient.

- | | | | | | |
|--|--|---|---|---|---|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Colitis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Irritable Colon | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> colon cancer | <input type="checkbox"/> Heart Attacks | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Spinal Disc Disorder |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> peptic ulcer | <input type="checkbox"/> STDs |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> hepatitis A | <input type="checkbox"/> kyphosis | <input type="checkbox"/> PMS | <input type="checkbox"/> stomach cancer |
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> juvenile diabetes | <input type="checkbox"/> hepatitis B | <input type="checkbox"/> leg pain | <input type="checkbox"/> Polio | <input type="checkbox"/> stomach ulcer |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> adult diabetes | <input type="checkbox"/> hepatitis C | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Profuse Menstrual | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dislocated Joints | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> lordosis | <input type="checkbox"/> prostate cancer | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Dizziness | <input type="checkbox"/> hip pain | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> traumatic arthritis |
| <input type="checkbox"/> Bone Cancer | <input type="checkbox"/> duodenum ulcer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> lower back pain | <input type="checkbox"/> Rapid Heart Rate | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> brain cancer | <input type="checkbox"/> Emphysema | <input type="checkbox"/> hypertension | <input type="checkbox"/> lung cancer | <input type="checkbox"/> rectum cancer | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Breast Soreness | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> hyperthyroidism | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> upper back pain |
| <input type="checkbox"/> breast cancer | <input type="checkbox"/> esophageal cancer | <input type="checkbox"/> hypotension | <input type="checkbox"/> migrane | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Vaginal Discharge |
| <input type="checkbox"/> Bulemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> hypothyroidism | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> gouty arthritis | <input type="checkbox"/> Irregular Bowel Habits | <input type="checkbox"/> neck pain | <input type="checkbox"/> shoulder pain | <input type="checkbox"/> _____ |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Irregular Menstrual | <input type="checkbox"/> osteo arthritis | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> _____ |

Select all choices that apply to the patient's family (please do not include relations by marriage).

- | | | | | | |
|--|--|---|---|---|---|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Colitis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Irritable Colon | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Sinus Trouble |
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| <input type="checkbox"/> Bulemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> hypothyroidism | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> gouty arthritis | <input type="checkbox"/> Irregular Bowel Habits | <input type="checkbox"/> neck pain | <input type="checkbox"/> shoulder pain | <input type="checkbox"/> _____ |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Irregular Menstrual | <input type="checkbox"/> osteo arthritis | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> _____ |

Patient exercises: Moderately Occasionally Rarely Regularly Never

Patient smokes: 2 packs per day 1/2+ pack per day Never _____
 2+ packs per day 1 pack per day 1/2 pack a day or less _____

Patient uses alcohol: Excessively Moderately Occasionally Rarely Never

Medication the patient is currently taking: Muscle Relaxants No prescription Psychotropic _____
 Analgesics Birth Control No non-prescription medications medication _____
 Anti-Inflamatory Hypertension medication Tranquilizers Vitamin supplements _____

Allergies - please mark all that apply: Dust Penicillan Pollen Sulfa Drugs
 Animal Dander Dairy Products Latex Perfumes Secondary Smoke No known allergies

Who is/was your most recent general physician? _____

What was his/her diagnosis? _____

Who was your last Doctor? _____

What were his/her findings? _____

Please list any previous injuries and/or accidents with approximate dates: _____

Past Surgical History (include date, location, surgeon's name, the type of surgery, and list complications)

Past Hospitalizations (date, complications, and cause of hospitalization)
