



HEALTH HISTORY FORM

Name _____ Date _____ Age _____ DOB _____

Bone & Joint Doctor _____ Family Doctor _____

Referred by: _____ Pharmacy: _____

Problem you are here for: _____

Work related: (Yes or No) Report of injury filed with employer (Yes or No)

Date symptoms started: _____ Right _____ Left _____

Explain: _____

Dominant Hand: Right Left Ambidextrous

LIST ALL PRESENT MEDICATIONS & DOSAGES:

Over the Counter _____ Aspirin Products _____

Herbal/Home Remedies/Vitamins _____

Diet Pills _____ Birth Control _____

Medications _____

List any medical problems you are currently being treated for or take medication for.

INCLUDE THE NAME OF THE PHYSICIAN WHO HELPS MANAGE THE PROBLEM.

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

Have you ever received a blood transfusion? (Yes or No)

Have you ever had a chronic infection such as Hepatitis, MRSA, VRE or HIV? (Yes or No) Circle all that apply

LIST ALLERGIES OR REACTIONS TO MEDICATIONS/LATEX/TAPE/IODINE/METAL _____

List **ALL** previous surgeries, and broken bones:

	<u>Description</u>	<u>Year</u>	<u>Hospital</u>	<u>Right/Left</u>
1.	_____			
2.	_____			
3.	_____			
4.	_____			
5.	_____			
6.	_____			

List any past hospitalizations:

FAMILY HISTORY

	<u>Circle</u>	
Father	Alive	Deceased
Mother	Alive	Deceased
Maternal Grandfather	Alive	Deceased
Maternal Grandmother	Alive	Deceased
Paternal Grandfather	Alive	Deceased
Paternal Grandmother	Alive	Deceased
Siblings: Brothers _____ Sisters _____	Healthy? Yes No (If no, indicate below)	

Is there any Family History of the following with your parents, grandparents, siblings, or children?

	<u>Circle</u>	<u>Who</u>
TB	Yes No	_____
Diabetes	Yes No	_____
Heart Trouble	Yes No	_____
High Blood Pressure	Yes No	_____
Arthritis	Yes No	_____
Blood Clots	Yes No	_____
Bleeding	Yes No	_____
Cancer	Yes No	_____
Malignant Hyperthermia	Yes No	_____

(a reaction to anesthesia)

Other, explain: _____

SOCIAL HISTORY

Smoking: YES NO packs per day:_____ years:_____

Street drug use: YES NO _____

Exercise: YES NO type:_____ frequency: _____

Outside activities/recreational hobbies: YES NO type:_____ frequency:_____

Caffeine: YES NO type:_____ frequency: _____

Marital status: _____

Children: YES NO Number of sons:_____ Number of daughters:_____ Healthy YES NO

Alcohol: YES NO type:_____ frequency:_____ years: _____

Occupation:_____ Employer:_____

Do you work with metal? YES NO

Have you ever welded? YES NO

REVIEW OF SYSTEMS:

Please answer yes or no to each of these categories. If you answer yes please draw a circle around each symptom you are having.

(This section pertains to the patient, not family members)

Constitutional symptom:

In the past 6 months have you had any unexplained fever, chills, night sweats or weight changes?
YES NO

Eyes:

In the past 6 months have you experienced any changes with your vision such as blurred or double vision, pain or flashes of light? YES NO

Ear, Nose, Mouth, Throat:

In the past 6 months have you had any changes with your hearing, nasal discharge or nose bleeds, mouth or throat sores? Lumps or stiffness in the neck? YES NO

Endocrine

In the past 6 months have you experienced any increase in your thirst, appetite or frequency of urination? Have you had any unexplained weight loss or gain? Heat or cold intolerances?
YES NO

Cardiovascular:

In the past 6 months have you had any chest pain, palpitations, heart problems, swelling, blood pressure or circulation problems? Have you ever seen a cardiologist? have you ever been treated for a blood clot? YES NO

Respiratory:

In the past 6 months have you experienced any breathing difficulties, shortness of breath cough or wheezing? Have you ever been exposed to Tuberculosis? YES NO
Do you snore? YES NO Have you ever been told you have sleep apnea? YES NO

Gastrointestinal:

In the past 6 months have you had any difficulty eating or swallowing, nausea or vomiting, abdominal pain, heartburn, blood in your stool or changes in bowel habits? YES NO

Genitourinary:

In the past 6 months have you had any changes in the way you empty your bladder, frequency, burning, or pain, or blood in your urine? Have you noticed any unusual discharge? YES NO

Female Patients:

Are you possibly pregnant? YES NO UNKNOWN

Male Patients:

In the past 6 months have you had testicular pain, masses or discharge? Do you have a history of testicular or prostate cancer? Have you ever been told you have an enlarged prostate? YES NO

Musculoskeletal:

In the past 6 months have you had any stiffness, pain, or swelling in your joints, weakness, redness or limitations of motion? YES NO

Neurological:

In the past 6 months have you experienced any dizziness, fainting, or blackouts, slurred speech, one-sided weakness, numbness, tingling, tremors or seizures? YES NO

Integumentary (Skin and/or breast):

In the past 6 months have you experienced any change in your skin, such as itching, dryness, color changes, rashes, lumps, or lesions, changes in hair or nails? YES NO

Hematologic/Lymphatic:

In the past 6 months have you had any changes with your blood such as easy bruising or bleeding? Any clotting problems or blood infections? Past transfusions and/or transfusion reactions? Do you take medication to thin your blood? YES NO

Psychiatric:

In the past 6 months have you had any episodes of deep sadness or anxiety? Thoughts of suicide, any memory changes? YES NO

Explanations: _____

VITALS: Height _____ Weight: _____