Health History

Name:____ **Date of birth:**___________________

Present complaints: **How long?**

1.____ ___________________________

2.____ ___________________________

3.____ ___________________________

4.____ ___________________________

Personal Medical History

___Headaches/migraines
___High blood pressure
___Heart attack/disease
___Diabetes
___Thyroid disease
___Back/spine surgeries
___Cancer
___Spinal/nerve disorders
___Stroke
___Hernia
___Chronic diarrhea/constipation
___Gall bladder disease
___Hepatitis
___Concussion/head injury
___Seizures/epilesy
___Depression/anxiety
___Gout
___Chronic rashes/ulcers
___Shortness of breath
___ Asthma
___COPD/bronchitis
___Frequent/painful urination
___Kidney stones
___Sexual dysfunction
___History of STDs
___Heart palpitations
___Chest pain

___Other serious or chronic illness or conditions ____

Medications:

1. ____ 5. ____

2. ____ 6. ____

3. ____ 7. ____

4. ____ 8. ____

Allergies to medications: ____

Do you smoke? Y / N How many years? _________ *Drink alcohol? Y / N* How often? ____________
Did you smoke? Y / N How long ago did you quit? ___________ Many yrs did you smoke? ____________

Was this condition caused by an accident? Y / N ____

Previous significant injuries or surgeries: ____

Family History

Father: Age _____ Health history ________________________________ Deceased/age/cause __________

Mother: Age _____ Health history ________________________________ Deceased/age/cause __________

Siblings: Age(s)/number ________________________ Health history ________________________________

Women only: Pregnant Y / N

Signature: ____ Date: _______________________