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
- ☐ Cancer
- ☐ Spinal/nerve disorders
- ☐ Stroke
- ☐ Hernia
- ☐ Chronic diarrhea/constipation
- ☐ Gall bladder disease
- ☐ Hepatitis
- ☐ Concussion/head injury
- ☐ Seizures/ epilepsy
- ☐ Depression
- ☐ Anxiety/PTSD
- ☐ Chronic rashes/ulcers
- ☐ Gout
- ☐ Asthma
- ☐ COPD/bronchitis
- ☐ Frequent/painful urination
- ☐ Kidney stones
- ☐ Sexual dysfunction
- ☐ History of STIs
- ☐ 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? ☐ *How many years?* _____ *Drink alcohol?* ☐ How often? ☐

Did you smoke? ☐ *How long ago did you quit?* ☐ Many yrs did you smoke? ☐

Was this condition caused by an accident? ☐ _____

*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 ☐

Signature: _____ Date: _____