Patient History Form

Name:_____ **Date of Birth:**_____ **Age:**_____ **Today's Date:**_____

Primary Reason for visit today:_____

Personal Health History
Check each of the health conditions you have now or have had in the past. Please enter the approximate date of onset below each item.

Cardiovascular	**Pulmonary**	**Musculoskeletal**	**Other Conditions**
□ Heart Attack	□ Asthma	□ Arthritis	□ Thyroid Disease
□ Angina	□ Emphysema	□ Low Back Pain	□ Pancreatitis
□ Bypass Surgery	□ COPD	□ Back Surgery	□ High Blood Pressure
□ Angioplasty	□ Recurrent Pneumonia	□ Hip Replacement	□ Polycystic Ovarian Syndrome
□ Heart Valve Disease	□ Pulmonary Hypertension	□ Knee Replacement	□ Seizures
□ Heart Valve Surgery	□ Lung Cancer	□ Other Joint Surgery	□ Breast Cancer
□ Pacemaker	□ Tuberculosis	□ Fibromyalgia	□ Colon Cancer
□ Defibrillator Implant	□ Chronic Bronchitis	□ Muscle Pain	□ Other Cancer
□ Atrial Fibrillation	□ Other:	□ Rotator Cuff Disorder	□ Bowel Polyps
□ Arrhythmias		□ Sciatica	□ Inflammatory Bowel disease
□ Mitral Valve Prolapse		□ Chronic Fatigue	□ Irritable Bowel Syndrome
□ Stroke	**Psychosocial**	□ Other:	□ Reflux (GERD)
□ TIA or "mini-stroke"	□ Depression		□ Stomach Ulcer
□ Carotid Blockage	□ Stress		□ Hepatitis
□ Leg Artery Blockage	□ Anxiety		□ Cirrhosis/Liver disease
□ Bypass Surgery	□ Nervous Disorder		□ Weight loss/gain
□ Stent placement			□ Kidney disease
□ Other:	□ Other:	□ Other:	□ High Cholesterol

Surgical History (Please list all surgeries with approximate date and surgeon):

1._____ 2._____

3._____ 4._____

5._____ 6._____

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Describe your current state of health: (please circle)

Excellent Very good Good Fair Poor

Family History
Please indicate whether your father, mother, sisters, or brothers have had any of the following conditions.

	Father	Mother	Brother	Sister	Paternal Grandparents	Maternal Grandparents
Living? (check if "yes")						
History unknown						
Heart attack, bypass, angioplasty before age 55						
Heart attack, bypass, angioplasty after age 55						
Diabetes						
High Blood Pressure						
Elevated Cholesterol						
Stroke						
Colon Cancer						
Breast Cancer						
Other Cancer/Malignant						
Arthritis, any type						
Thyroid disease						
Alcoholism						

Social History:

Marital Status: □ Single □Married □Separated □Divorced □Widow(er)

Occupation:_____Current Employer:_____

How much caffeine(coffee, tea, soda,etc.) do you drink? _____

Number servings per day?_____ week?_____

How much alcohol do you drink? Drinks per day?_____ week? _____ month?_____

Do you use tobacco? □ No □ Yes Type: Cigarettes Cigars Snuff/Chew Quit/Date?_____

Number of packs/day:_____ Number of years you smoked:_____

Have you ever used marijuana, cocaine, other drugs? □ No □ Yes

Other Physicians or Practitioners Participating in your care: (ie. MDs, chiropractors, etc.)

_____
_____
_____

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_____
_____

Medications/Vitamins/Supplements/Birth Control

Name of Pharmacy: _____ **Phone #:** _____

Prescription Plan: _____

Do you want prescriptions filled for 30 days or 90 days? _____

Please list all PRESCRIPTION MEDICATIONS:

Name of Drug	Dose	Times per Day

Please list name and dose of all over the counter medications you currently take:

Vitamins/Minerals: _____

Dietary Supplements: _____

Aspirin: _____ Strength: _____

Herbal Products: _____

Pain Relief Products: _____

Allergies (medications/latex)? Please list type of reaction to each

_____

_____