

# HEALTH HISTORY

## MEDICAL HISTORY

Patient Name \_\_\_\_\_ Height \_\_\_\_ ft \_\_\_\_ in Weight \_\_\_\_\_ lbs.

Name of Family Physician \_\_\_\_\_ Address \_\_\_\_\_

May they be contacted regarding your condition?  Yes  No

Treatments you have already received for your condition?  Medications  Surgery  Physical Therapy  Chiropractic Adjustments  
 None  Other \_\_\_\_\_

Name(s) of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal Exam \_\_\_\_\_ Dental X-Ray \_\_\_\_\_  
 Spinal X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

**Indicate if you (Self) or someone in your family (Fam) have had the following:**

AIDS/HIV	<input type="checkbox"/> Self	Gout	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Multiple	Tuberculosis	<input type="checkbox"/> Self <input type="checkbox"/> Fam	
Anemia	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Heart Disease	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Sclerosis	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Tumors/Growths	<input type="checkbox"/> Self <input type="checkbox"/> Fam
Arthritis	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Hepatitis	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Osteoporosis	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Ulcers	<input type="checkbox"/> Self <input type="checkbox"/> Fam
Asthma	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Hernia	<input type="checkbox"/> Self	Pacemaker	<input type="checkbox"/> Self	Venereal	
Bleeding Disorders	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Type _____ Herniated Disk	<input type="checkbox"/> Self	Parkinson's Disease	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Disease	<input type="checkbox"/> Self <input type="checkbox"/> Fam
Bronchitis	<input type="checkbox"/> Self	Where _____		Prostate		Other _____	
Cancer	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Herpes	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Problem	<input type="checkbox"/> Self <input type="checkbox"/> Fam		
Chemical Dependency	<input type="checkbox"/> Self <input type="checkbox"/> Fam	High Cholesterol	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Prosthesis	<input type="checkbox"/> Self	<b>Women only:</b>	
Diabetes	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Kidney Disease	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Where _____		Breast Lump	<input type="checkbox"/> Self <input type="checkbox"/> Fam
Eating Disorder	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Liver Disease	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Psychiatric Care	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Vaginal	
Emphysema	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Lung Disease	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Stroke	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Infections	<input type="checkbox"/> Self <input type="checkbox"/> Fam
Epilepsy	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Migraines	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Suicide Attempt	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Goiter	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Mononucleosis	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Thyroid Problems	<input type="checkbox"/> Self <input type="checkbox"/> Fam	Due Date _____	

**EXERCISE**

None  
 Moderate  
 Daily  
 Heavy

**WORK ACTIVITY**

Hours working per day \_\_\_\_\_  
 Hours sitting \_\_\_\_\_  
 Hours standing \_\_\_\_\_  
 Average weight lifting \_\_\_\_\_

**HABITS**

Smoking Packs/Day \_\_\_\_\_  
 Alcohol Drinks/Week \_\_\_\_\_  
 Coffee/Caffeine Drinks Cups/Day \_\_\_\_\_  
 High Stress Level Reason \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Do you have any metal in your body?  Yes  No Where? \_\_\_\_\_

**MEDICATIONS**

**ALLERGIES**

**VITAMINS/MINERALS/HERBS**

_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone _____	_____	_____