Health History Form

Patientís Name:_____ **Date:**_____

Address:_____ **City:**_____ **State:**____ **Zip:**_____

Phone #:_____ **Date of Birth:** _____ **Age:**_____ **Gender:**____

Please mark the intensity of your pain today.

1 – NO PAIN
10 – MOST INTENSE EVER FELT

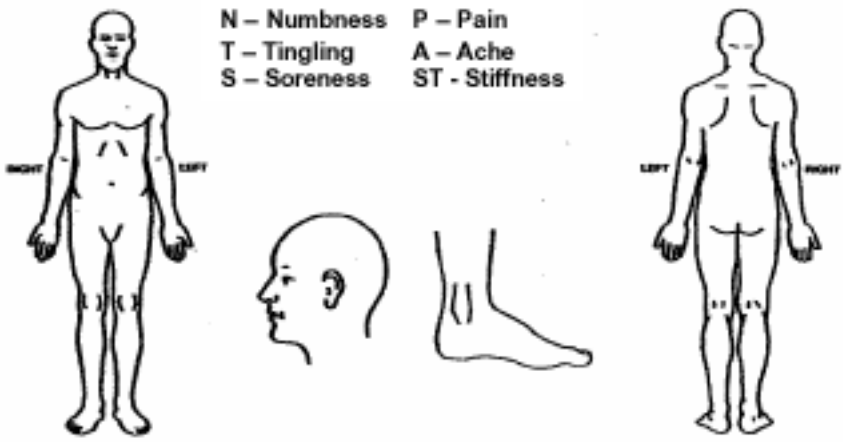
Example Neck 1 2 3 (4) 5 6 7 8 9 10

1. _____ 1 2 3 4 5 6 7 8 9 10
2. _____ 1 2 3 4 5 6 7 8 9 10
3. _____ 1 2 3 4 5 6 7 8 9 10

OFFICE USE ONLY

Please mark area & type of pain on the drawing using the code below.

N – Numbness P – Pain
T – Tingling A – Ache
S – Soreness ST - Stiffness



HABITS

- ❒ Smoking Packs/Day _____
- ❒ Drinking Alcohol _____
- ❒ Coffee Cups/Day _____

EXERCISE

- ❒ None
- ❒ Moderate
- ❒ Daily

Type

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	❒	❒	❒	❒	❒
Father	❒	❒	❒	❒	❒
Brother, No. of ____	❒	❒	❒	❒	❒
Sister, No. of ____	❒	❒	❒	❒	❒

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

- ❒ Appendicitis
- ❒ Pneumonia
- ❒ Rheumatic Fever
- ❒ Polio
- ❒ Tuberculosis
- ❒ Whooping Cough
- ❒ Anemia
- ❒ Measles
- ❒ Mumps
- ❒ Chicken Pox
- ❒ Diabetes
- ❒ Cancer
- ❒ Heart Disease
- ❒ Goiter
- ❒ Influenza
- ❒ Pleurisy
- ❒ Alcoholism
- ❒ Venereal Infection
- ❒ Arthritis
- ❒ Epilepsy
- ❒ Mental Disorder
- ❒ Lumbago
- ❒ Eczema
- ❒ HIV Positive

OPERATIONS AND PROCEDURES

DATE(S)		DATE(S)		DATE(S)	
_____	Vaccinations	_____	Tubes in Ears	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach
_____	Other	_____	Other	_____	Other