PATIENT HEALTH HISTORY QUESTIONNAIRE

The following information is very important to your plan of care. Please take time to fully and completely fill out this important information. We are counting on you.

Please complete every section. Do not leave any blanks.

NAME: _____ **DOB:**_____ **AGE:**_____ **TODAY'S DATE:**_____

HT: _____ **WT:** _____ **SEX:** M F ☐ Right hand dominant ☐ Left hand dominant

FAMILY DR: _____ **REFERRING DR:** _____

DRUG ALLERGIES or ADVERSE REACTIONS: ☐ NO ☐ YES – Please list: _____

_____

IF YOU ARE ALLERGIC TO ANY OF THE FOLLOWING, PLEASE CIRCLE:

SHELLFISH* IODINE* X-RAY DYE* EGGS* POULTRY* FEATHERS* LATEX*

LIST ALL MEDICATIONS (INCLUDE SUPPLEMENTS) and Include Dosage: ☐ NO Medications

_____

_____

_____

YOUR PAST MEDICAL HISTORY-Please mark every line

DO YOU HAVE NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES	NO	Comments		YES	NO	Comments
Anemia	☐	☐	_____	**High Blood Pressure**	☐	☐	_____
Anxiety	☐	☐	_____	**High Cholesterol**	☐	☐	_____
Asthma	☐	☐	_____	**Irregular Heart Rate**	☐	☐	_____
Back Disorder	☐	☐	_____	**Kidney Disease**	☐	☐	_____
Blood Clots	☐	☐	_____	**Lung Disease**	☐	☐	_____
Blood Disease	☐	☐	_____	**Mental Disease**	☐	☐	_____
Blood in Urine	☐	☐	_____	**MRSA/Serious Infection***	☐	☐	_____
Cancer (Location)	☐	☐	_____	**Neuropathy**	☐	☐	_____
Colitis / Irritable Bowel	☐	☐	_____	**Osteoporosis**	☐	☐	_____
Depression	☐	☐	_____	**Osteoarthritis**	☐	☐	_____
Diabetes	☐	☐	_____	**Prostate Problems**	☐	☐	_____
Emphysema	☐	☐	_____	**Sleep Apnea**	☐	☐	_____
Epilepsy / Seizures	☐	☐	_____	**Stroke**	☐	☐	_____
Gallbladder Disease	☐	☐	_____	**Rheumatoid Arthritis**	☐	☐	_____
Gout	☐	☐	_____	**Thyroid Disease**	☐	☐	_____
Heart Disease	☐	☐	_____	**Ulcers (Stomach)**	☐	☐	_____
Hepatitis / Liver Disease*	☐	☐	_____	**Venereal Disease / STD**	☐	☐	_____
HIV/AIDS*	☐	☐	_____	**Other-** _____			

YOUR PAST SURGICAL HISTORY

☐ None ☐ Yes- please explain:_____

_____

_____

FAMILY / SOCIAL HISTORY – Please mark every area

Significant Medical History in Your:	YES	NO	Comments (family member affected)
Mother	☐	☐	_____
Father	☐	☐	_____
Siblings	☐	☐	_____
Children	☐	☐	_____
Specifically in your family members:			
Spine Disorders	☐	☐	_____
Arthritis/Joint Problems	☐	☐	_____
Cancer	☐	☐	**Location:** _____

Social History: Do you…	YES	NO	If YES, Please explain:
Smoke?	☐	☐	_____
Use alcohol?	☐	☐	_____
Use illegal drugs?	☐	☐	_____

MARITAL STATUS: Single Married Widowed Divorced **OCCUPATION:** _____

REVIEW OF SYSTEMS – Please mark every area

Have you recently been troubled with any of the following symptoms?

	YES	NO		YES	NO
Fatigue	☐	☐	**Abdominal Pain**	☐	☐
Fever	☐	☐	**Indigestion**	☐	☐
Night Sweats	☐	☐	**Constipation**	☐	☐
Weight Loss	☐	☐	**Diarrhea**	☐	☐
Rash	☐	☐	**Blood in Stool**	☐	☐
Heat/Cold Intolerance	☐	☐	**Abnormal Bleeding/Bruising**	☐	☐
Chest Pain/Pressure	☐	☐	**Weakness/Paralysis**	☐	☐
Irregular heart beat	☐	☐	**Balance Difficulty**	☐	☐
Shortness of Breath	☐	☐	**Headache**	☐	☐
Wheezing	☐	☐	**Depression**	☐	☐
Change in Bowel Habits	☐	☐	**Anxiety**	☐	☐

Other Concerns: _____

The above information is true and correct to the best of my belief.

_____ _____

Patient Signature (Parent or Guardian for Minor) / Date **Physician Signature / Date**

MA/REVIEWER INITIALS: _____