

HEALTH HISTORY FORM

NAME: _____ DOB: _____ TODAY'S DATE: _____
LAST FIRST MIDDLE

HEIGHT: _____ feet _____ inches WEIGHT: _____ pounds DOMINANT HAND: R L

IF FEMALE, ARE YOU OR COULD YOU BE PREGNANT? NO YES

REASON FOR TODAY'S VISIT: _____

DATE OF INJURY OR ONSET OF PROBLEM: _____

IS THIS WORK RELATED? NO YES REPORTED TO EMPLOYER? NO YES

IS THIS RELATED TO AN ACCIDENT? NO YES AUTO OTHER _____

DO YOU HAVE LEGAL ACTION PENDING REGARDING THIS ? NO YES NAME OF ATTORNEY: _____

PAST MEDICAL HISTORY:

List all current medical problems:

List all current medications:

List all drug allergies, including adverse reaction: NONE LATEX

PAST SURGICAL HISTORY:

Have you ever had any problems with anesthesia? : NO YES Explain _____

Table with 4 columns: SURGERY, YEAR, SURGERY, YEAR. Includes dotted lines for data entry.

FAMILY HISTORY

Table with 2 main sections for family history. Each section has columns for Mother, Father, Siblings and rows for Heart Disease, Stroke, Diabetes, Seizures, Kidney Disease, Osteoarthritis, Blood Clots, Cancer, High Blood Pressure, Mental Illness, Thyroid Disease, Bleeding Disorders, Rheumatoid Arthritis, and OTHER—explain: _____

HEALTH HISTORY FORM

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

LAST
FIRST
MIDDLE

REVIEW OF SYSTEMS:

Are you currently having or have you had problems with:

	NO	YES		NO	YES
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Lungs, Breathing , Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Digestion, Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Bladder/Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems/Chest Pain (including rheumatic fever)	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems/Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Balance Problems	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>	Blackout/Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Depression/Psychological Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Old Fracture	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Reaction	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Wound problems	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

DESCRIBE ALL YES RESPONSES:

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SOCIAL HISTORY

Occupation: _____

Smoker NO YES _____ packs per day for _____ years
 Quit smoking NO YES When? _____
 Previously smoked _____ packs per day for _____ years
 Chew tobacco? NO YES How much? _____
 Drink alcohol? NO YES How much and how often? _____
 History of substance abuse/recreational drugs? NO YES What? _____

Do you live alone? NO YES
 Children? NO YES # _____

Patient Signature _____ **Date** _____
Reviewed by _____ **Date** _____
MD Signature _____ **Date** _____

Update _____ by _____ Update _____ by _____
 Update _____ by _____ Update _____ by _____