Date:

HEALTH HISTORY QUESTIONNAIRE

Name *(First, M.I, Last):* ☐ M ☐ F **DOB:** **Age:**			
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Address:	**City, State, Zip:**		
Home Phone: ( ) -	**Cell Phone: ( ) -**	**Cell Carrier:**	☐ Texting is acceptable
Email Address:	**Preferred Contact Number:** ☐ Home ☐ Cell		
Emergency Contact:	**Phone Number: ( ) -**	**Relationship:**	
Previous or referring doctor:	**Date of last physical exam:**		
How did you hear about us?			

EMPLOYER

Business Name:	**Occupation/Job Title:**
Work Phone: ( ) -	
Repetitive Activities: ☐**Computer** ☐**Phone** ☐**Machinery** ☐**Hand Tools** ☐**Assembly** ☐**Grasping** ☐**Heavy Lifting**	

PAYMENT

Who is responsible for your bill? ☐ **Self/Non-Insurance** ☐ **Please verify my insurance benefits** ***(Provide insurance card)***		
Insurance Holder:	**Holder's DOB:**	**Relationship to patient:**

PERSONAL HEALTH HISTORY

Childhood Illnesses:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio			
Immunizations and Dates:	☐ Tetanus	☐ Pneumonia		
	☐ Hepatitis	☐ Chickenpox		
	☐ Influenza *(Flu Shot)*	☐ Other		
Medical Conditions:	☐ Diabetes Type ____	☐ Heart Disease_____	☐ Cancer (Type_____)	
	☐ Hypertension	☐ Lupus	☐ Fibromyalgia	☐ CVA (Stroke)
	☐ Other:			
Surgeries and Dates:	☐ Joint Replacement	☐ Joint Reconstruction	☐ Spinal Fusion	
	☐ Laminectomy	☐ Rotator Cuff		
	☐ Other:			
	Year	Surgery	Year	Surgery
Injuries and Dates:	☐ Broken Bones	☐ Severe Fall	☐ Joint Injury	
	☐ Head Injury	☐ Back Injury	☐ Car Accident	
	☐ Other:			

Do you wear any of the following: ☐ Heel lifts ☐ Innersoles ☐ Arch Supports ☐ Orthotics

MEDICATIONS

List your prescribed drugs and over-the-counter drugs. (Attached list is preferable if possible.)

Drug Name	Dosage	Frequency Taken

Please list any allergies to medication.

REVIEW OF SYSTEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

CONSTITUTIONAL	GASTROINTESTINAL	PSYCHOLOGIC
☐ Weight Gain	☐ Nausea	☐ Depression
☐ Weight Loss	☐ Abnormal Stool Consistency	☐ Insomnia
☐ Fatigue	☐ Vomiting	☐ Mood Change(s)
EYES/VISION	**ENDOCRINE**	**SKIN**
☐ Wear glasses and/or contact lenses	☐ Diabetes	☐ Rash
☐ Change in vision	☐ Cold Intolerance	☐ Hair Loss
☐ Double vision	☐ Excessive Thirst	☐ Paresthesia (numbness, prickling, tingling)
RESPIRATION	**HEMATOLOGY**	**NERVOUS SYSTEM**
☐ Cough	☐ Anemia	☐ Headaches
☐ Shortness of breath	☐ Blood Clotting	☐ Limb Weakness
☐ Asthma	☐ Bruises Easily	☐ Seizures
EARS, NOSE, AND THROAT	**CARDIOVASCULAR**	☐ Numbness
☐ Dizziness	☐ Heart Problems	☐ Memory Loss
☐ Headaches	☐ Chest Pain	**OTHER**
☐ Head Injury (history of)	☐ Palpitations (irregular or forceful heartbeat)	☐
☐ Loss of Smell	☐ Heart Murmor	☐

WOMEN ONLY

I am:	☐ Currently Pregnant	☐ In Menopause	☐ N/A
My menses cycle is:	☐ Regular	☐ Irregular	☐ N/A
Heavy periods, irregularity, spotting, pain, or discharge?		☐ Yes	☐ No
Number of pregnancies:			
Are you pregnant or breastfeeding?		☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?		☐ Yes	☐ No
Do you experience hot flashes or sweating at night?		☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?		☐ Yes	☐ No

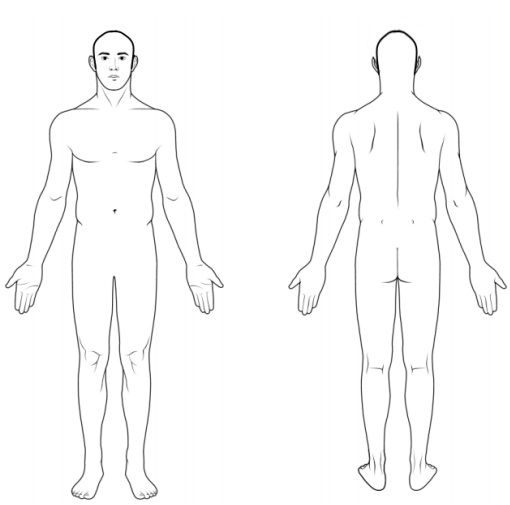
MEN ONLY		
Do you usually get up to urinate during the night?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No

HEALTH HABITS AND PERSONAL SAFETY						
Exercise	☐ Sedentary (no exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week or more for 30 minutes)					
Diet	Are you eating what you consider a healthy diet?				☐ Yes	☐ No
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?	☐ Occasionally	☐ Often	☐ Social Consumption	☐ Never	
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational drugs?				☐ Yes	☐ No
Personal Safety	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No

MENTAL HEALTH		
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No

FAMILY HEALTH HISTORY					
	AGE	**SIGNIFICANT HEALTH HISTORY**		**AGE**	**SIGNIFICANT HEALTH HISTORY**
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

CURRENT CONDITION

Chief Complaint						
Condition	☐ New	☐ Recurring	☐ New Episode	☐ Chronic		
Onset & Date	☐ Auto/Work Accident		☐ Slept Wrong			
	☐ Overexertion/Repetitive Use		☐ Unknown/No Injury			
	☐ Slip/Fall		☐ Other			
Symptoms & Locations	☐ Pain	☐ Numbness	☐ Stiffness			
	☐ Weakness					
	☐ Other:					
Quality	*Please use the designated letters, arrows, and circles to indicate on the diagram the areas of current complaint.*					
	☐ Burning (B)	☐ Dull/Achy (A)				
	☐ Diffuse (D)	☐ Tightness (T)				
	☐ Sharp (S)	☐ Localized (L)				
	☐ Shooting (Sh)	☐ Tingling (Ti)				
	☐ Stabbing (St)	☐ Throbbing (Th)				
	☐ Other:					
	☐ Additional Notes:					
	Does the pain radiate or travel to another location?	☐ No	☐ Yes	If yes, where?		
Associated Symptoms	☐ Blurred Vision	☐ Depression	☐ Dizziness	☐ Irritability/ Mood Swings	☐ Nausea	☐ Ringing in Ears
	☐ Headaches	Location: ☐ Occipital	☐ Frontal	☐ Temporal	☐ Parietal	☐ Sinus
		Quality: ☐ Dull	☐ Sharp	☐ Throbbing	☐ Stabbing	☐ Aura ☐ No Aura
		Type: ☐ Hat Band	☐ Cluster	☐ Migraine	☐ Tension	
	☐ Other:					
Scale 0-10, 10 Being the Worse	How do you rate your discomfort while you are resting?	0 1 2 3 4 5 6 7 8 9 10				
	While performing activities?	0 1 2 3 4 5 6 7 8 9 10				
Timing & Context	Worse in the:	☐ Morning	☐ Afternoon	☐ Night	☐ With Activity	☐ Constant ☐ Intermittent
	Better with:	☐ Heat	☐ Cold	☐ Movement	☐ Rest	☐ Meds ☐ Stretching
History of Condition	Have you seen other doctors for this condition?	☐ No	☐ Yes	If yes, who?		
	Type of treatment?	Outcome of treatment?				
Activities	*Please indicate which activities your current condition affects. Please use the following key to illustrate severity.* N = no effect (not painful) , C = can do activity (painful) , L = limited ability (painful) , U = unable to perform					
	☐ Driving	☐ Carrying	☐ Changing Position	☐ Stairs		
	☐ Care for Family	☐ Computer	☐ Chores	☐ Yard Work		
	☐ Walking	☐ Prolonged Standing	☐ Prolonged Sitting	☐ Self Care		
	☐ Sleep	☐ Lifting	☐ Golf	☐ Swimming		
	☐ Bowling	☐ Tennis	☐ Hiking	☐ Running		
	☐ Other					