



Health History

Today's Date: _____
 Patient's Name: _____
 Birthdate: _____
 Address: _____
 Phone No: _____
 Are you Right or Left Handed? (circle one)
 Referring Physician: _____
 Family Physician: _____
 Pharmacy: _____

Chief Complaint

Have you seen other physicians for your current complaint?
 If yes, please list the physicians and dates you saw them in.

Have you had treatment for you current complaints? Yes or No
 If yes, please state approximately when and by whom.

CT'S, MRI'S, ULTRASOUND, X-RAYS, OR OTHER DIAGNOSTIC TESTING

Have you had CT'S, MRI'S, Ultrasounds or X-Rays made for
 your current complaints? Yes or No
 If yes, by whom.

PAST SURGICAL HISTORY

List and indicate approximate year.

CURRENT MEDICATIONS OR ATTACH MEDICATION LIST

ALLERGIES

PAST HISTORY (PERSONAL)

| | | |
|--------------------------|-----|------|
| Measles | Yes | No |
| Mumps | Yes | No |
| Chicken pox | Yes | No |
| Whooping Cough | Yes | No |
| Scarlet Fever | Yes | No |
| Diphtheria | Yes | No |
| Smallpox | Yes | No |
| Pneumonia | Yes | No |
| Rheumatic Fever | Yes | No |
| Heart Disease | Yes | No |
| Heart Surgery | Yes | No |
| Pacemaker | Yes | No |
| Heart Valve Replacement | Yes | No |
| Anemia | Yes | No |
| Epilepsy | Yes | No |
| Migraine Headaches | Yes | No |
| Tuberculosis | Yes | No |
| Diabetes | Yes | No |
| Cancer | Yes | No |
| | | Type |
| Polio | Yes | No |
| Glaucoma | Yes | No |
| Hernia | Yes | No |
| Blood Transfusion | Yes | No |
| Back Trouble | Yes | No |
| High Blood Pressure | Yes | No |
| Hemorrhoids | Yes | No |
| Asthma | Yes | No |
| Bladder Infections | Yes | No |
| Colitis | Yes | No |
| Bleeding Tendency | Yes | No |
| Bronchitis | Yes | No |
| Stroke | Yes | No |
| Emphysema | Yes | No |
| Ulcer | Yes | No |
| Kidney Disease | Yes | No |
| Thyroid Disease | Yes | No |
| AIDS/HIV | Yes | No |
| Angina Pectoris | Yes | No |
| Gout | Yes | No |
| Frequent Lung infections | Yes | No |
| Lupus | Yes | No |

FAMILY HISTORY

| | | Relationship | | | | | |
|-----------------------|-----|---------------------|-------|----------------------|-----|-----|-------|
| Relationship | | Yes | No | | | Yes | No |
| Multiple Sclerosis | Yes | No | _____ | Stroke | Yes | No | _____ |
| Tuberculosis | Yes | No | _____ | Epilepsy | Yes | No | _____ |
| Diabetes | Yes | No | _____ | Allergies | Yes | No | _____ |
| Heart Disease | Yes | No | _____ | Anemia | Yes | No | _____ |
| High blood pressure | Yes | No | _____ | Bleeding Tendency | Yes | No | _____ |
| Asthma | Yes | No | _____ | Chronic Lung Disease | Yes | No | _____ |
| Drug/Alcohol Problems | Yes | No | _____ | Dementia/Alzheimer's | Yes | No | _____ |
| Migraine Headaches | Yes | No | _____ | Thyroid Disease | Yes | No | _____ |
| Cancer | Yes | No | _____ | Depression | Yes | No | _____ |
| High Cholesterol | Yes | No | _____ | Kidney Disease | Yes | No | _____ |
| Glaucoma | Yes | No | _____ | Gout | Yes | No | _____ |
| Parkinson's | Yes | No | _____ | Neck/Back Trouble | Yes | No | _____ |
| Tremor | Yes | No | _____ | Neuropathy | Yes | No | _____ |

PERSONAL HABITS

- Check if you smoke regularly.
Cigarettes _____ Number per day _____ Pipe _____ Cigar _____
How long have you been smoking? _____
- Check if you drink regularly.
Hard liquor 1 - 3 oz day _____ Over 3 oz per day _____
Beer 1 bottle per day _____ 2 bottles per day _____ 3 or more bottles per day _____
Wine 1 glass per day _____ 2 glasses per day _____ 3 or more glasses per day _____
- Do you drink coffee, tea or soft drinks?
3 or more cups per day _____ Caffeinated _____ Decaffeinated _____
- Do you have trouble sleeping? Never _____ Often _____ Sometimes _____
- Do you awaken very early in the morning without apparent cause and find it difficult to fall asleep again?
Frequently _____ Occasionally _____ Rarely _____
- Do you use marijuana, cocaine or other drugs? Yes _____ No _____

OCCUPATIONAL

What is your occupation? _____
Are you presently employed? Yes _____ No _____

MARITAL/FAMILY

What is your marital status?
Married _____ Single _____ Widowed _____ Divorced _____
Have there been any deaths in your family or among close friends in the past year or two? Yes _____ No _____
Does anyone in your family have a serious illness or disability? Yes _____ No _____
Does anyone in your family have a drug or alcohol problem? Yes _____ No _____

SOCIAL HISTORY

Have you recently lived or traveled outside the U.S.? Yes _____ No _____
Are you a high school graduate or equivalent? Yes _____ No _____
Did you attend or complete college? Yes _____ No _____
Have you ever served in the military? Yes _____ No _____
Have you ever been rejected for life or health or had to pay an extra premium? Yes _____ No _____
Have you ever been treated for a drinking problem? Yes _____ No _____

CURRENT PHYSICAL/OT/OR SLP

PAST THERAPIES DATES

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Patient Name _____ DOB _____

Review of Systems:

1. General

Do you feel depressed a lot of the time? Yes No
 Has there been any unusual weight gain? Yes No
 or loss recently? Yes No
 If yes, Gained _____ Loss _____ Stable _____
 If gained or loss how much? _____

Have you ever passed blood from your rectum? Yes No
 Have you ever had black or tarry stools? Yes No
 Have you noticed any recent changes in
 your bowel movements? Yes No

1. Skin

Have you noticed?
 The appearance of new dark spots? Yes No
 Any skin rashes or itching? Yes No
 Any growths on your skin that bothers
 you? Yes No
 Any sores or wounds that do not heal? Yes No
 Any change in color or size of warts or
 moles? Yes No

8. Genitourinary

Do you have:
 Burning or pain when you urinate? Yes No
 To urinate frequently? Yes No
 Trouble urinating? Yes No
 To get up at night to urinate? Yes No
 Trouble with losing urine when you
 you cough or sneeze? Yes No
 Have you ever passed blood in you urine? Yes No
 Men, do you have prostate gland trouble? Yes No

2. Eyes

Have you had any pain in your eyes? Yes No
 Have you had glaucoma? Yes No

9. Musculoskeletal

Do you have a problem with back pain? Yes No
 Does back pain interfere with your work
 or activities? Yes No
 Frequent or severe nosebleeds? Yes No
 Do you have joint pain, stiffness or
 swelling? Yes No
 Falls or fear of falling? Yes No

3. Ear, Nose, Throat

Any trouble hearing? Yes No
 Ringing or buzzing in your ears? Yes No
 A lump in your throat? Yes No
 A sore tongue or mouth? Yes No
 Bleeding gums? Yes No
 Difficulty speaking or swallowing Yes No

10. Central Nervous System

Do you have frequent or severe
 headaches? Yes No
 Do you often have spells of dizziness,
 faintness or lightheadedness? Yes No
 Have you ever see double vision? Yes No
 Do you sometimes lose track of what is
 around you for a short time? Yes No
 Do you sometimes lose the ability to
 speak for a few seconds? Yes No
 Have you recently fainted, blacked out or
 lost consciousness? Yes No
 Do you have trouble remembering recent
 events? Yes No
 Have you ever had convulsions or fits? Yes No
 Do you have numbness or tingling in your
 head, arms or legs? Yes No

4. Respiratory

Do you have:
 A constant or bothersome cough? Yes No
 Coughing of blood? Yes No
 Difficulty breathing? Yes No
 Have you noticed any wheezing or
 whistling in your chest? Yes No

5. Cardiovascular

Do you have pain, tightness or pressure
 in front or back of your chest? Yes No
 electrocardiogram was abnormal? Yes No
 Do you have swelling of you feet or
 Ankles? Yes No
 Does your heart ever beat fast or
 irregularly? Yes No
 Do you have cramps in the calf muscles
 when you walk? Yes No

11. Women Only

A. Premenopausal women:

Did your menstrual period start after you
 were 15? Yes No
 Are you menstrual periods irregular? Yes No
 Do you use more than 10 pads or have to
 use a super size pad or tampon for you
 periods? Yes No
 Do you pass clots with you periods? Yes No
 Do you become bloated or gain weight
 just before you periods? Yes No

B. Postmenopausal women:

At what age did you go through the menopause? _____

C. All women:

Have you had any abortions
 or miscarriages? Yes No
 Have you had any lumps in your breasts? Yes No
 Have you ever had a mammogram? Yes No
 If so, when? _____

6. Gastrointestinal

Have your recently noted any trouble
 Swallowing? Yes No
 Do you have a lot of indigestion or
 Heartburn? Yes No
 Have you ever vomited blood? Yes No
 Are you bothered with constipation? Yes No
 Do you have frequent nausea and/or
 vomiting? Yes No

 Do you have frequent loose stools or
 diarrhea? Yes No

Patient Name _____

DOB _____