



## 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 DIAGNOTIC 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
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

Type

**FAMILY HISTORY**

		<b>Relationship</b>					
<b>Relationship</b>		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  
 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

## 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? \_\_\_\_\_

## 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

## 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 \_\_\_\_\_