HEALTH HISTORY

Office use only:
Vital Signs: Temp _____ Ht._____ Wt. _____

Patient Name: _____**DOB**:_____**AGE**:_____

Referred by: _____PCP: _____

Reason for today's visit_____

Related to: ❑MVA ❑Slip and Fall ❑W/C claim Injury Date: _____

WHERE IS THE PAIN LOCATED: _____
HOW SEVERE ARE THE SYMPTOMS: ❑ Mild ❑ Moderate ❑ Severe
SYMPTOM START DATE: _____
What Makes It Better/Worse? _____

Past History:

☐Hypertension ☐Diabetes ☐Heart Disease ☐ Lung Disease ☐High Cholesterol ☐Cancer
Other: _____
Diseases: ☐HIV ☐TB ☐Hepatitis A B C D (If yes, circle which one)
Previous Surgeries/Hospitalizations:
_____
_____

Please indicate any personal history below:

☐Const: ☐Fatigue ☐Weight loss/gain ☐Fever
☐Eyes: ☐Vision Change ☐Glasses ☐Contacts
☐ENT: ☐Hearing loss ☐Vertigo ☐Chronic sinus problems ☐Sore Throat
☐CV: ☐Heart disease ☐Chest pain ☐Palpitations ☐Shortness of Breath ☐Feet swelling
☐Resp: ☐Shortness of Breath ☐Cough ☐Wheezing
☐GI: ☐Nausea/vomiting ☐Diarrhea ☐Constipation ☐ Abdominal Pain
☐GU: ☐Frequent urination ☐ Blood in Urine ☐ Kidney Stones
☐M/S: ☐Muscle weakness/pain/cramps ☐Back pain ☐Bone pain ☐Fractures
☐Skin ☐Rash ☐Itching ☐Lesions ☐Bruising ☐Nail changes ☐Tattoos ☐Scars
☐Neuro: ☐Numbness/tingling ☐Headaches ☐Head injury
☐Heme: ☐Easy Bruising ☐Blood clots ☐ Anemia

Family History:

☐ Hypertension ☐Cardiac Disease ☐Cancer ☐Diabetes

Other _____

Are you pregnant: ☐YES ☐NO

Social History:

Marital ☐ S ☐M ☐ D ☐ W

Alcohol _____ Drugs_____

Smoking ☐No ☐Yes how long _____

Allergies to medicines: _____
_____

_____ _____
Signature **Date**