

PATIENT HEALTH HISTORY

Name: _____

Date: _____

Date of Birth: _____, Age: _____ Gender: _____ Weight: _____ lbs / Height: _____ in

Describe present symptoms:

On a scale of 0 - 10 (0 = No Pain, 10 = Severe Pain) how would you rate your pain today? _____

Allergies: Seasonal Peanuts Tree Nuts Other: _____

Past Medical History: *Check all current and previous conditions.*

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease / Problems | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Heartburn / Acid reflux |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Heart Attacks | <input type="checkbox"/> Asthma | <input type="checkbox"/> Ulcers / Colitis |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Heart Arrhythmias | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Neurological Issues |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Bowel / Bladder Irregularities | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Depression / Anxiety |
| <input type="checkbox"/> Thyroid Issues | <input type="checkbox"/> Stroke | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Other (list below): |

Please describe any current or past medical history not listed above:

Please list **ALL** hospitalizations or past surgeries along with surgical **dates**:

Please list any medications or supplements you are currently taking along with the dosage (include vitamins and herbal):

Social & Preventative History:

- | | | | |
|---|-----|----|---------------------------------|
| Do you currently use any tobacco products? | Yes | No | If yes, how often? |
| Do you drink alcoholic beverages? | Yes | No | If yes, how often? |
| Do you drink caffeinated beverages? | Yes | No | If yes, how often? |
| Do you exercise / engage in physical activity / play sports >3 days per week? | Yes | No | If yes, please list activities: |

- | | | | | |
|--|--------|--------|--------------|-------|
| How often do you wear a seatbelt while in a vehicle? | Always | Mostly | Occasionally | Never |
| Do you consider yourself at risk for a fall? | Yes | No | | |
| Have you had a fall in the past year? | Yes | No | | |
| Are you currently working? | Yes | No | | |

If yes, what is your occupation? _____

If no, what is your status? Retired Disabled Temporary Leave / Sick Leave Other

By signing, I hereby certify that all the information provided in this document is accurate and true, to the best of my knowledge.

Patient / Guardian Signature

Date