HEALTH HISTORY
Date:_____
Patient Name: _____Height_____ Weight_____
**Chief Complaint:_____ Location_____ Duration_____**
**Severity_____ (How Severe is the pain on a scale of 1-5 )**

**Past Medical History:** Have you ever had the following: (Circle "no" or "yes")

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Measles | no | yes | Heart Disease | no | yes | Back Trouble | no | yes | Hepatitis | no | yes |
| Mumps | no | yes | High blood pressure | no | yes | Arthritis | no | yes | Ulcer | no | yes |
| Chickenpox | no | yes | Low blood pressure | no | yes | Diabetes | no | yes | Polio | no | yes |
| Whooping cough | no | yes | Mitral valve prolapse | no | yes | Anemia | no | yes | Any other | | |
| Scarlet fever | no | yes | Rheumatic fever | no | yes | Cancer | no | yes | Diseases or | | |
| Diphtheria | no | yes | Blood transfusions | no | yes | AIDS or HIV+ | no | yes | Syndrome: | | |
| Smallpox | no | yes | Migraine headaches | no | yes | Stroke | no | yes | | | |
| Pneumonia | no | yes | Bleeding tendencies | no | yes | Glaucoma | no | yes | | | |
| Bronchitis | no | yes | Kidney disease | no | yes | Epilepsy | no | yes | Last chest | | |
| Tuberculosis | no | yes | Bladder infections | no | yes | Hernia | no | yes | x-ray date: | | |
| Asthma | no | yes | Infectious mono | no | yes | Hemorrhoids | no | yes | | | |
| Venereal Disease | no | yes | Hives or eczema | no | yes | Thyroid disease | no | yes | | | |

**Previous Hospitalizations/Surgeries/Serious Illnesses** **When?** **Hospital,City,State**

_____ _____ _____
_____ _____ _____
_____ _____ _____

**Medications(include nonprescription)**_____
_____
_____
Have you ever taken Fen-Phen/Redux? no yes

**Patient social history:**
Marital status: Single:____ Married:____ Separated:____ Divorced:____ Widowed:_____
Use of alcohol: Never:____ Rarely: ____ Moderate:_____ Daily:_____
Use of Tobacco: Never:_____ Previously, but quit_____ Current packs/day:_____
Use of drugs: Never_____ Type/Frequency:_____

**Family medical history:**

| | Age | Diseases | If Deceased, Cause of Death |
|---|---|---|---|
| Father | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ |
| Siblings | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| Spouse | _____ | _____ | _____ |
| Children | _____ | _____ | _____ |
| | _____ | _____ | _____ |