

CONFIDENTIAL HEALTH HISTORY

Name _____

Date _____

In the box in front of each item, enter (X) if you currently have or had in the past the problem. Please leave the box blank if it does not apply. Past conditions are marked in the first box and Current conditions in the second.

GENERAL

<u>Past</u>	<u>Current</u>
<input type="checkbox"/>	<input type="checkbox"/> Fever
<input type="checkbox"/>	<input type="checkbox"/> Chills
<input type="checkbox"/>	<input type="checkbox"/> Night Sweats
<input type="checkbox"/>	<input type="checkbox"/> Loss of sleep
<input type="checkbox"/>	<input type="checkbox"/> Fatigue
<input type="checkbox"/>	<input type="checkbox"/> Nervousness
<input type="checkbox"/>	<input type="checkbox"/> Weight Loss/Gain
<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Bleeding Problem
<input type="checkbox"/>	<input type="checkbox"/> Anemia
<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Cancer
<input type="checkbox"/>	<input type="checkbox"/> Thyroid
<input type="checkbox"/>	<input type="checkbox"/> Disease/Goiter
<input type="checkbox"/>	<input type="checkbox"/> Alcoholism
<input type="checkbox"/>	<input type="checkbox"/> Drug Abuse
<input type="checkbox"/>	<input type="checkbox"/> HIV positive
<input type="checkbox"/>	<input type="checkbox"/> Other _____

EYE EAR NOSE THROAT

<u>Past</u>	<u>Current</u>
<input type="checkbox"/>	<input type="checkbox"/> Poor Vision
<input type="checkbox"/>	<input type="checkbox"/> Pain in Eye(s)
<input type="checkbox"/>	<input type="checkbox"/> Difficulty Hearing/Deaf
<input type="checkbox"/>	<input type="checkbox"/> Nosebleeds
<input type="checkbox"/>	<input type="checkbox"/> Nose Problems
<input type="checkbox"/>	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/>	<input type="checkbox"/> Dental Problems
<input type="checkbox"/>	<input type="checkbox"/> Hoarseness
<input type="checkbox"/>	<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/>	<input type="checkbox"/> Other _____

GASTROINTESTINAL

<u>Past</u>	<u>Current</u>
<input type="checkbox"/>	<input type="checkbox"/> Poor Appetite
<input type="checkbox"/>	<input type="checkbox"/> Poor Digestion
<input type="checkbox"/>	<input type="checkbox"/> Difficulty Swallowing
<input type="checkbox"/>	<input type="checkbox"/> Belching or Gas
<input type="checkbox"/>	<input type="checkbox"/> Frequent Nausea
<input type="checkbox"/>	<input type="checkbox"/> Vomiting
<input type="checkbox"/>	<input type="checkbox"/> Vomiting Blood
<input type="checkbox"/>	<input type="checkbox"/> Pain over Abdomen
<input type="checkbox"/>	<input type="checkbox"/> Ulcer
<input type="checkbox"/>	<input type="checkbox"/> Black or Bloody Stools
<input type="checkbox"/>	<input type="checkbox"/> Liver Problems
<input type="checkbox"/>	<input type="checkbox"/> Gall Bladder Problems
<input type="checkbox"/>	<input type="checkbox"/> Jaundice
<input type="checkbox"/>	<input type="checkbox"/> Hernia
<input type="checkbox"/>	<input type="checkbox"/> Diarrhea
<input type="checkbox"/>	<input type="checkbox"/> Constipation
<input type="checkbox"/>	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/>	<input type="checkbox"/> Appendicitis
<input type="checkbox"/>	<input type="checkbox"/> Other _____

RESPIRATORY

<u>Past</u>	<u>Current</u>
<input type="checkbox"/>	<input type="checkbox"/> Difficult Breathing
<input type="checkbox"/>	<input type="checkbox"/> Chronic Cough
<input type="checkbox"/>	<input type="checkbox"/> Spitting Phlegm
<input type="checkbox"/>	<input type="checkbox"/> Spitting Blood
<input type="checkbox"/>	<input type="checkbox"/> Asthma/Wheezing
<input type="checkbox"/>	<input type="checkbox"/> Pneumonia
<input type="checkbox"/>	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/> Other _____

CARDIOVASCULAR

<u>Past</u>	<u>Current</u>
<input type="checkbox"/>	<input type="checkbox"/> Irregular Heartbeat
<input type="checkbox"/>	<input type="checkbox"/> High blood pressure
<input type="checkbox"/>	<input type="checkbox"/> Pain over Heart
<input type="checkbox"/>	<input type="checkbox"/> Previous Heart Trouble
<input type="checkbox"/>	<input type="checkbox"/> Ankle Swelling
<input type="checkbox"/>	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/>	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/> Stroke
<input type="checkbox"/>	<input type="checkbox"/> Other _____

GENITOURINARY

<u>Past</u>	<u>Current</u>
<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Painful Urination
<input type="checkbox"/>	<input type="checkbox"/> Blood in Urine
<input type="checkbox"/>	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/> Urinary Infection
<input type="checkbox"/>	<input type="checkbox"/> Inability to Control Urination
<input type="checkbox"/>	<input type="checkbox"/> Breast Lump or Pain
<input type="checkbox"/>	<input type="checkbox"/> Venereal Infection
<input type="checkbox"/>	<input type="checkbox"/> Sexual Difficulties
<input type="checkbox"/>	<input type="checkbox"/> Other _____

SKIN

<u>Past</u>	<u>Current</u>
<input type="checkbox"/>	<input type="checkbox"/> Itching
<input type="checkbox"/>	<input type="checkbox"/> Bruising easily
<input type="checkbox"/>	<input type="checkbox"/> Change in Mole(s)
<input type="checkbox"/>	<input type="checkbox"/> Dryness/Wetness
<input type="checkbox"/>	<input type="checkbox"/> Change in color
<input type="checkbox"/>	<input type="checkbox"/> Skin Cancer
<input type="checkbox"/>	<input type="checkbox"/> Other _____

WOMEN ONLY

<u>Past</u>	<u>Current</u>
<input type="checkbox"/>	<input type="checkbox"/> Live births
<input type="checkbox"/>	<input type="checkbox"/> Miscarriage
<input type="checkbox"/>	<input type="checkbox"/> Painful Periods
<input type="checkbox"/>	<input type="checkbox"/> Excessive Flow
<input type="checkbox"/>	<input type="checkbox"/> Irregular Cycles

WOMEN ONLY

<u>Past</u>	<u>Current</u>
<input type="checkbox"/>	<input type="checkbox"/> Vaginal Burning/Itching
<input type="checkbox"/>	<input type="checkbox"/> Hot Flashes

MEN ONLY

<u>Past</u>	<u>Current</u>
<input type="checkbox"/>	<input type="checkbox"/> Testicular Swelling/Pain
<input type="checkbox"/>	<input type="checkbox"/> Prostate problems
<input type="checkbox"/>	<input type="checkbox"/> Other _____

NEUROLOGICAL

<u>Past</u>	<u>Current</u>
<input type="checkbox"/>	<input type="checkbox"/> Weakness
<input type="checkbox"/>	<input type="checkbox"/> Twitching
<input type="checkbox"/>	<input type="checkbox"/> Tremors
<input type="checkbox"/>	<input type="checkbox"/> Headache
<input type="checkbox"/>	<input type="checkbox"/> Fainting
<input type="checkbox"/>	<input type="checkbox"/> Dizziness
<input type="checkbox"/>	<input type="checkbox"/> Convulsions
<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Numbness/Tingling
<input type="checkbox"/>	<input type="checkbox"/> Arm/Leg Pain
<input type="checkbox"/>	<input type="checkbox"/> Mental Disorder
<input type="checkbox"/>	<input type="checkbox"/> Other _____

MUSCULOSKELETAL

<u>Past</u>	<u>Current</u>
<input type="checkbox"/>	<input type="checkbox"/> Swollen Joints
<input type="checkbox"/>	<input type="checkbox"/> Spinal Curvature
<input type="checkbox"/>	<input type="checkbox"/> Arthritis
<input type="checkbox"/>	<input type="checkbox"/> Painful Joints
<input type="checkbox"/>	<input type="checkbox"/> Muscle Aches/Soreness
<input type="checkbox"/>	<input type="checkbox"/> Other _____

CHILDHOOD DISEASES

<input type="checkbox"/>	Mumps
<input type="checkbox"/>	Measles
<input type="checkbox"/>	Chickenpox
<input type="checkbox"/>	Other _____

SURGERIES

List dates and reasons:

HOSPITALIZATIONS

List dates and reasons

HABITS/ADDICTIONS

<input type="checkbox"/>	Smoking _____ packs/day
<input type="checkbox"/>	Alcohol
<input type="checkbox"/>	Coffee
<input type="checkbox"/>	Tea with caffeine
<input type="checkbox"/>	Soft drinks
<input type="checkbox"/>	Other _____

SLEEP

Hours per night _____

STRESS LEVELS

<input type="checkbox"/> High	<input type="checkbox"/> Medium
<input type="checkbox"/> Low	<input type="checkbox"/> None

EXERCISE

<input type="checkbox"/>	None
<input type="checkbox"/>	_____ times per week
Type	_____

ANY OTHER HEALTH CONCERNS?

Notes:

Reviewed by:

Scott Rosenthal, D.C.

Date _____