HEALTH HISTORY

Date: _____

Name: _____

Referring Physician: _____

Reason for Evaluation:_____

_____

Age: _____ Gender: Male ____ Female ____ Dominant Hand: Left ____ Right____

Height: _____ Weight: _____

ALLERGIES: List any allergies you have.

_____

_____

_____

MEDICATIONS: List any drug or medication that you take.

_____

_____

_____

PAST HISTORY:

___ High Blood Pressure
___ Diabetes
___ High Cholesterol
___ Stroke
___ TIA (transient ischemic attack)
___ Depression
___ Anxiety
___ Cancer
___ Peripheral Vascular Disease
___ Gastric Reflux
___ Thyroid Disease
___ Asthma
___ COPD/Emphysema
___ Blood Clots
___ Atrial Fibrillation
___ Arrhythmia
___ Kidney Disease
___ Epilepsy
___ Bleeding
___ HIV
___ Anemia
___ Urinary Incontinence
___ Lupus
___ Rheumatoid Arthritis
___ Spinal Cord Injury
___ Blood Transfusions
___ Hepatitis
___ Heart Disease
___ Heart Attack
___ Glaucoma
___ Coronary Artery Disease
___ Other: _____

Name: _____ **HEALTH HISTORY CONTINUED…**

PAST SURGICAL HISTORY. List all surgeries you had in the past

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

HOSPITALIZATIONS:_____

SOCIAL HISTORY:

Place of Birth:_____

Occupation: _____

Highest Education Level: _____

Marital Status: Single ___ Married ___ Separated ___ Divorced ___ Widowed ___

Tobacco: No ___ Yes ___ If yes, amount _____

Have you ever smoked? ____ When did you quit? _____

Use of Alcohol: Never ___ Rarely ___ Occasional ___ Moderate ___ Daily ___ Drinks per week___

Use Of Recreational Drugs: Never ___ Type/Frequency_____

Exercise: Never ___ Occasionally ___ Regularly ___ Times per week _____

FAMILY HISTORY:

	Age	Medical problems		Age	Medical problems
Father	____	_____	Maternal Grandmother	____	_____
Mother	____	_____	Maternal Grandfather	____	_____
Siblings	____	_____	Paternal Grandmother	____	_____
Children	____	_____	Paternal Grandfather	____	_____
			Other	____	_____

Name: _____

HEALTH HISTORY CONTINUED

REVIEW OF SYMPTOMS:
(Please check all current, active symptoms)

Headaches
___ Nausea/Vomiting
___ Light Sensitivity
___ Visual Changes
___ Positional (Lying/Standing)
___ Prior Head Injury
___ Menstrual Induced

Weakness/Decreased Function
___ Swallowing trouble
___ Head Heaviness
___ Falls/Difficulty Walking
___ Muscle Loss/Weakness
___ Cramps/Twitching
___ Muscle Pain
___ Muscle/Joint Stiffness
___ Slowness
___ Slurred Speech

Spine
___ Bowel/Bladder/Sexual Problems
___ Numbness/Tingling Pain
___ Arm(s) _____
___ Leg(s) _____
___ Body _____
___ Weakness
___ Neck/Back Pain

GU/Sexual
___ Frequent Urination
___ Difficulty Urinating
___ Incontinence
___ Sexual Problems

Gastrointestinal
___ Abdominal Pain
___ Loss of Appetite
___ Nausea/Vomiting
___ Frequent Diarrhea
___ Painful Bowel Movements or Constipation
___ Rectal Bleeding/Blood in Stool

Sleep
___ Tiredness
___ Snoring
___ Breath Cessation/Gasping
___ Frequent Awakenings
___ Leg Kicks/Restlessness
___ Sleep Walk/Talk
___ Weight Gain
Upon Awakening/Falling Asleep
___ Sleep Paralysis
___ Hallucinations
Upon Emotional Situations
___ Sudden Muscle Weakness (i.e. Jaw drop, Knees buckle)
___ Insomnia
___ Delayed Onset of Sleep
___ Trouble Staying Asleep
___ A.M. Headache, Dry Mouth, Sore throat

Seizures
___ Warning Symptom (Aura)
___ Confusion (Before/After)
___ Head Injury
___ Prior Seizure
___ Urinary Incontinence
___ Tongue Biting
___ Head Turning
___ Staring
___ Blackout

Constitutional
___ Fever/Chills
___ Weight Gain/Loss

Integumentary (Skin/Breast)
___ Change in Hair or Nails
___ Breast Pain
___ Rash or Itching

Eyes
___ Wear Glasses
___ Eye Disease
___ Double/Blurred Vision

Tremor
___ Slow Movements
___ Drooling
___ Masked Face (Expression)
___ Stiff
___ Weakness
___ Tremor During Rest
___ Tremor with Activity
___ Poor balance/Coordination

Dizziness
___ Light Headed
___ Vertigo/Spinning
___ Disequillibrium/Woozy

Ears/Nose/Mouth/Throat
___ Trouble Swallowing
___ Hearing Loss
___ Ringing in Ears
___ Earaches/Drainage
___ Chronic Sinus Problems/Rhinitis
___ Sore Throat/Voice Change
___ Other _____

Cardiovascular/Respiratory
___ Swelling of feet, ankles, or hands
___ Weight Gain
___ Heart trouble
___ Chest Pain/Angina Pectoris
___ Palpitations
___ Shortness of Breath
___ Wheezing
___ Chronic/Frequent Cough

Miscellaneous
___ Excessive Thirst or Urination
___ Heat/Cold Intolerance
___ Skin Dryness
___ Cold Hands or Feet
___ Glandular or Hormone Problem
___ Anemia
___ Anxiety, Stress
___ Depression
___ Memory Loss/Difficulty Concentrating