PATIENT HEALTH HISTORY

Name: ____ Age: ___________ Date: _____________

Sex: Male Female Marital Status: Single Married Divorced Widowed # Children: ________

Chief Complaint - List Current Problems:

1. ____ Duration (How Long) __________

2. ____ Duration (How Long) __________

3. ____ Duration (How Long) __________

Please mark the intensity of your pain today

1- NO PAIN
10 - MOST INTENSE EVER FELT

Example	Neck									
	1	2	3	(4)	5	6	7	8	9	10
1.	1	2	3	4	5	6	7	8	9	10
2.	1	2	3	4	5	6	7	8	9	10
3.	1	2	3	4	5	6	7	8	9	10

DOCTOR'S USE ONLY

Please mark area & type of pain on the drawings using the code listed below

N -Numbness P- Pain T- Tingling
A- Ache S - Soreness ST - Stiffness

HABITS

☐ Smoking Packs/Day___________
☐ Drinking Alcohol/Day__________
☐ Coffee Cups/Day____________

EXERCISE

☐ None
☐ Moderate
☐ Daily
Type: _________

FAMILY HISTORY

	Diabetes	Heart	Cancer	Back
Mother	☐	☐	☐	☐
Father	☐	☐	☐	☐
Brother, No. of _____	☐	☐	☐	☐
Sister, No. of _____	☐	☐	☐	☐

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

☐ Appendicitis
☐ Pneumonia
☐ Rheumatic Fever
☐ Polio
☐ Tuberculosis
☐ Whooping Cough
☐ Anemia
☐ Measles
☐ Mumps
☐ Chicken Pox
☐ Diabetes
☐ Cancer
☐ Heart Disease
☐ Goiter
☐ Influenza
☐ Pleurisy
☐ Alcoholism
☐ Venereal Infection
☐ Arthritis
☐ Epilepsy
☐ Mental Disorder
☐ Lumbago
☐ Eczema
☐ HIV Positive

OPERATIONS AND PROCEDURES

DATE

____________ Vaccinations
____________ Tonsillectomy
____________ Gall Bladder
____________ Back Operation
____________ Other:
____

DATE

____________ Tubes In Ears
____________ Appendectomy
____________ Female Organs
____________ Rectal Surgery
____________ Other:
____

DATE

____________ Sinus
____________ Hernia
____________ Thyroid
____________ Stomach
____________ Other:
____