HEALTH HISTORY

Date: __________

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Patient Name: ______________________

Birthdate: __________ Patient #: __________

Chief Complaint: ______________________

PATIENT LABEL MUST BE PLACED WITHIN THIS BOX

History of Present Illness:

Location: __________ (Where is the pain/problem?)

Quality: __________ (Example: normal versus abnormal color, activity, etc.)

Severity: __________ (How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

Duration: __________ (How long have you had this pain/problem, or, When did it start?)

Timing: __________ (Does the pain/problem occur at a specific time?)

Context: __________ (Where were you at the onset of this pain/problem?)

Associated signs/symptoms: __________ (What other associated problems have you been having?)

Modifying factors: __________ (What makes the pain/problem worse or better, or, Have you had previous episodes?)

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Condition			Condition			Condition			Condition		
Measles	no	yes	Anemia	no	yes	Back Trouble	no	yes	Hepatitis	no	yes
Mumps	no	yes	Bladder Infections	no	yes	High Blood Pressure	no	yes	Ulcer	no	yes
Chickenpox	no	yes	Epilepsy	no	yes	Low Blood Pressure	no	yes	Kidney Disease	no	yes
Whooping Cough	no	yes	Migraine Headaches	no	yes	Hemorrhoids	no	yes	Thyroid Disease	no	yes
Scarlet Fever	no	yes	Tuberculosis	no	yes	Date of Last Chest x-Ray	no	yes	Bleeding Tendency	no	yes
Diphtheria	no	yes	Diabetes	no	yes	Asthma	no	yes	Any other disease	no	yes
Smallpox	no	yes	Cancer	no	yes	Hives or Eczema	no	yes	(please list):		
Pneumonia	no	yes	Polio	no	yes	AIDS or HIV +	no	yes			
Rheumatic Fever	no	yes	Glaucoma	no	yes	Infectious Mono	no	yes			
Heart Disease	no	yes	Hernia	no	yes	Bronchitis	no	yes			
Arthritis	no	yes	Blood or Plasma			Mitral Valve Prolapse	no	yes			
Venereal Disease	no	yes	Transfusion	no	yes	Stroke	no	yes			

Previous Hospitalizations/Surgeries/Serious Illnesses

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

Medications: (Include nonprescription) ______________________

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: ____			
Excessive Exposure at home or work to:	Fumes: ____	Dust: ____	Solvents: ____	Air-borne Particles: ____	Noise: ____

Family Medical History:

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