

Health History Form

Patient's Name: _____ Date: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone #: _____ Date of Birth: _____ Age: _____ Gender: _____

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
 (4)

1. _____
 2. _____
 3. _____

OFFICE USE ONLY

Please mark area & type of pain on the drawing using the code below.

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

HABITS

- Smoking Packs/Day _____
- Drinking Alcohol _____
- Coffee Cups/Day _____

EXERCISE

- None
- Moderate
- Daily Type _____

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother, No. of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister, No. of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

- | | | | |
|--|--------------------------------------|---|--|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Measles | <input type="checkbox"/> Goiter | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Venereal Infection | <input type="checkbox"/> HIV Positive |

OPERATIONS AND PROCEDURES

DATE(S)		DATE(S)		DATE(S)	
_____	Vaccinations	_____	Tubes in Ears	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach
_____	Other	_____	Other	_____	Other

