Patient Health History Form

Current Medications

Please list all of your prescription, over-the-counter and herbal medications. If you have a list prepared, we would be happy to copy it for you.

Medication	Dosage	Frequency	Prescribed by	Reason for taking

Are you allergic or sensitive to any medications, latex, contrast dye, tape or foods? Yes No

If yes, please list below.

Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____

Current pharmacy: _____ Pharmacy phone: _____

Family Medical History

If applicable, please include high blood pressure, heart attack, stroke, TIA, aneurysm, bleeding disorder and cancer.

Family member	Alive (yes/no)	Age	Cause of death or current health status
Father			
Mother			
Brother/sister			
Brother/sister			

Brother/sister			
Brother/sister			
Son/daughter			
Son/daughter			
Son/daughter			
Son/daughter			
Paternal grandfather			
Paternal grandmother			
Maternal grandfather			
Maternal grandmother			

Personal/Social History

Marital status (circle one): single married divorced widowed

Number of children (circle one): 1 2 3 4 5 6

Do you live alone? Yes No If not, who do you live with? _____

Education level (circle one): high school technical school college graduate school other

Occupation: _____ Employer: _____

Years employed at present job: _____

Do you use tobacco products? Yes No

If yes, type(s): _____ Amount: _____

How many years have you used tobacco products? _____

If not, have you used tobacco in the past? Yes No

Type(s): _____ Amount: _____ Years: _____

Do you want to quit smoking? Yes No

Do you drink alcohol? Yes No

If yes, type(s): _____ Amount per week: _____

Do you have a history of alcohol abuse? Yes No

Do you use or have you ever used street/illicit drugs? Yes No

If yes, type(s): _____

Are you at risk for HIV/AIDS due to sexual orientation, behavior or intravenous drug use? Yes No

If yes, please explain: _____

Do you exercise? Yes No Type(s) and frequency: _____

Hobbies: _____

Chief Complaint

Reason for today's visit: _____

Date of onset: _____

Where are your symptoms/pain located? _____

Current Medical History

Please circle or check any that apply to you:

Seizures	Stroke	Hepatitis
Migraines	COPD/emphysema	HIV/AIDS
Cataracts	Asthma	Kidney stones
Sleep apnea	Hiatal hernia	Prostate problems
High blood pressure	Stomach reflux	Fibromyalgia
Heart valve problems	Peptic ulcers	Chronic fatigue
Heart disease	Bowel/bladder problems	Arthritis
High cholesterol	Thyroid disease	Depression
Blood clotting disorder	Diabetes	Cancer

Other: _____

Are you right- or left-handed? _____

Are you claustrophobic? Yes No

Do you have metal in your body? Yes No If yes, explain: _____

Do you have a pacemaker? Yes No Are you off work due to this problem? Yes No

If yes, off since: _____

Current problem result of (circle one): auto accident work accident fall repetitive motion lifting unknown other: _____

Illnesses, Surgeries & Hospitalizations

Illness/surgery	Year	Physician/hospital	Complications

Previous Treatments

Please check any boxes that apply:

Treatment	Tried	No change	Helped	Worsened
Physical therapy				
Injections				
Trigger point				
Epidural steroid (amount: ____)				
Non-steroidal anti-inflammatory				
Narcotics				
Muscle relaxants				
Neck or back brace				
TENS				
Therapeutic massage				
Chiropractic therapy				
Pain management specialist				
Other: _____				