

## Patient Health History

Please complete all areas that are in **BOLD**

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male \_\_\_ Female \_\_\_

**ALLERGIES:** \_\_\_\_\_

**Who referred you today:** \_\_\_\_\_

**Why are you here today?:** \_\_\_\_\_

**Duration of pain/symptoms:** \_\_\_\_\_

**Have you ever had prior problems/injuries with this body part? If yes, please explain?** \_\_\_\_\_

**Which pharmacy do you use?** \_\_\_\_\_

**PAST MEDICAL HISTORY:** Are you currently or have you been treated for any of the following conditions.

	Yes	No		Yes	No
Asthma			Ulcer/Acid Reflux/GERD		
Tuberculosis			Osteoporosis/Osteopenia		
COPD			Hypo/Hyperthyroidism		
Heart Disease/Pacemaker			Diabetes Type I/Type II		
Heart Attack/ Angina			Renal Failure/Kidney Disease		
High Blood Pressure			Cancer:		
Anemia			Sexually Transmitted Disease/HIV/AIDS		
Peripheral Vascular Disease			Lyme Disease		
History of Blood Transfusion			Rheumatoid Arthritis/Lupus		
Psoriasis			Gout		
Blood Clot/ DVT			History of Prednisone or Steroid Medication		
Stroke			Other:		

**PAST SURGICAL HISTORY**

**Please list any previous hospitalizations or surgeries you have had, the dates, and surgeons.**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**MEDICATIONS:** Please list any prescription or over-the-counter you currently take:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Can you take anti-inflammatory medications like aspirin, Motrin (ibuprofen), Aleve (naproxen)? Yes No Unsure**



Name \_\_\_\_\_

**For Office Use Only**

Age: \_\_\_\_\_

Vitals: Height \_\_\_\_\_

Weight \_\_\_\_\_

Pulse \_\_\_\_\_

Respiration \_\_\_\_\_

HPI: (by patient report)

EXAM

PLAN