

Health History

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

Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so or by court order.

Name: _____ Date of Birth : _____ Todays date : _____

Reason for your visit: _____

Who is your Primary Care Physician (Name Address City and Phone # & Hospital Affiliation): _____
(If the patient is a child then who is their pediatrician)

History of current problem: Location: _____ (Where is the pain or problem?) Pain: _____ (On a scale of 1-10 with 10 being the most severe?)
Duration: _____ (How long have you had this pain/problem?) Timing: _____ (Does the pain/problem occur at a specific time?)

Have you been treated by another physician for this or have you tried anything on your own: (explain): _____

Past Medical History:

Have you ever had or do you have any of the following: (Circle Yes or No Leave, a "?" next to the problem if uncertain)

Yes No...Anemia	Yes No...Glaucoma	Yes No...Heart Palpitations or Fluttering
Yes No...Appendicitis	Yes No...Gout Infection	Yes No...Pneumonia
Yes No...Arthritis or Rheumatism	Yes No...Headaches	Yes No...Polio
Yes No...Back Trouble	Yes No...Heart Disease	Yes No...Rheumatic Fever
Yes No...Bladder Disease	Yes No...Hepatitis	Yes No...Scarlet Fever
Yes No...Bleeding Tendency	Yes No...Hernia	Yes No...Seizures
Yes No...Blood Transfusions	Yes No...High Blood Pressure	Yes No...Shortness of Breath
Yes No...Bone or Joint Disease	Yes No...HIV or AIDS	Yes No...Sinus Problem
Yes No...Bronchitis	Yes No...Hives or Eczema	Yes No...Broken or Cracked Bones
Yes No...Jaundice	Yes No...Slow to heal after cuts	Yes No...Stomach Problems / Acid Reflux
Yes No...Bursitis or Sciatica	Yes No...Kidney Disease	Yes No...Stroke
Yes No...Cancer _____	Yes No...Leg Cramps (walking or at night)	Yes No...Swelling of Feet or Ankles
Yes No...Chicken Pox	Yes No...Loss or change in the sensation of hands or feet	Yes No...Swelling of Joints
Yes No...Colitis	Yes No...Low Blood Pressure	Yes No...Thyroid Disease
Yes No...Diabetes	Yes No...Migraines	Yes No...Tingling of feet of hands
Yes No...Diphtheria	Yes No...Mitral Valve Prolapse	Yes No...Tonsillitis / Tonsillectomy
Yes No...Enlarged Veins in Legs	Yes No...Neuritis or Neuralgia	Yes No...Tuberculosis
Yes No...Epilepsy	Yes No...Night Sweats	Yes No...Ulcers
Yes No...Gallbladder Disease		Other _____

Hospitalizations

Have you ever been **hospitalized / had surgeries** / or any serious illnesses not listed above? If yes list the problem & date or year.

Have you ever been advised to have any **surgical operation which has not been done?** _____

Have you ever had a **cortisone injection?** Where? When? _____

Are you currently taking any Medications: (Include nonprescription): _____

Allergies

Please circle if you are **allergic** to: Penicillin Sulfa Aspirin Codeine Morphine Mycins Adhesive Tape
Demerol Novocain Iodine Latex NONE

Are you **allergic** to any other drugs, medications or foods: _____

Patient Social History:

Use of Alcohol: Never Rarely Moderate Daily Type _____

Use of Tobacco: Never Previously, but quit: _____ Current packs / day: _____

Use of Drugs: Never Type / Frequency: _____

Current Weight: _____ Height _____ Shoe Size _____

What type of shoe do you wear at: home _____ work _____ non work _____

Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient, Parent or Guardian

Date

Doctor's Review: