PERSONAL HEALTH HISTORY

Name _____ Today's Date _____

We need your complete health report before we can be responsible for your case.
Had in the past CHECK the box. Currently have CIRCLE the item.

Muscle/Joint
- ❑ Arthritis
- ❑ Bursitis
- ❑ Foot Trouble
- ❑ Hernia
- ❑ Low Back Pain
- ❑ Lumbago
- ❑ Neck Pain, Stiffness
- ❑ Pain Between Shoulders

General
- ❑ Allergies
- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting
- ❑ Fatigue
- ❑ Fever
- ❑ Headache
- ❑ Loss of Sleep
- ❑ Loss of weight
- ❑ Nervousness, Depression
- ❑ Neuralgia
- ❑ Numbness
- ❑ Tremors

Cardiovascular
- ❑ Hardening of Arteries
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Pain Over Heart
- ❑ Poor Circulation
- ❑ Rapid Heart Beat
- ❑ Slow Heart Beat
- ❑ Swelling of Ankles

Genitourinary
- ❑ Bed Wetting
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Lack of Bladder Control
- ❑ Kidney Infections
- ❑ Painful Urination
- ❑ Prostate Trouble
- ❑ Pus in the Urine

Eye, Ear, Nose, Throat
- ❑ Asthma
- ❑ Crossed Eyes
- ❑ Deafness
- ❑ Dental Decay
- ❑ Earaches
- ❑ Ear Discharge
- ❑ Ear Noise
- ❑ Enlarged Glands
- ❑ Enlarged Thyroid
- ❑ Eye Pain
- ❑ Failing Vision
- ❑ Far Sightedness
- ❑ Gum Disease
- ❑ Hay Fever
- ❑ Hoarseness
- ❑ Nasal Obstruction
- ❑ Near Sightedness
- ❑ Nose Bleeds
- ❑ Sinus Infections
- ❑ Sore Throat
- ❑ Tonsillitis

Gastrointestinal
- ❑ Belching or Gas
- ❑ Colitis
- ❑ Colon Trouble
- ❑ Constipation
- ❑ Diarrhea
- ❑ Difficult Digestion
- ❑ Bloated Abdomen
- ❑ Excessive Hunger
- ❑ Gall Bladder Trouble
- ❑ Hemorrhoids
- ❑ Intestinal Worms
- ❑ Jaundice
- ❑ Liver Trouble
- ❑ Nausea
- ❑ Pain Over Stomach
- ❑ Poor Appetite
- ❑ Vomiting
- ❑ Vomiting Blood

Skin
- ❑ Boils
- ❑ Bruise Easily
- ❑ Dry Skin
- ❑ Hives or Allergies
- ❑ Itching
- ❑ Skin Eruptions
- ❑ Varicose Veins

Pain or Numbness In:
- ❑ Shoulders
- ❑ Arms
- ❑ Elbows
- ❑ Hands
- ❑ Hips
- ❑ Legs
- ❑ Knees
- ❑ Feet
- ❑ Poor Posture
- ❑ Sciatica
- ❑ Spinal Curvature
- ❑ Swollen Joints

Lungs
- ❑ Chest Pain
- ❑ Chronic Cough
- ❑ Difficulty Breathing
- ❑ Spitting up Blood
- ❑ Spitting up Phlegm
- ❑ Wheezing

Women Only
- ❑ Congested Breasts
- ❑ Cramps or Back ache
- ❑ Excess Menstrual Flow
- ❑ Hot Flashes
- ❑ Irregular Cycle
- ❑ Lumps in Breasts
- ❑ Menopause
- ❑ Painful Menstruation
- ❑ Vaginal Discharge

Are you pregnant?
❑ Yes ❑ No
If yes, how long? _____

Check any of the following conditions you have or have had:
- ❑ Alcoholism
- ❑ Anemia
- ❑ Appendicitis
- ❑ Arteriosclerosis
- ❑ Cancer
- ❑ Chicken Pox
- ❑ Chorea
- ❑ Cold Sores
- ❑ Diabetes
- ❑ Diphtheria
- ❑ Eczema
- ❑ Edema
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fever Blisters
- ❑ Goiter
- ❑ Gout
- ❑ Heart Disease
- ❑ Herpes
- ❑ Influenza
- ❑ Lumbago
- ❑ Malaria
- ❑ Measles
- ❑ Miscarriage
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pace Maker
- ❑ Pleurisy
- ❑ Pneumonia
- ❑ Polio
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Whooping Cough

Exercise
- ❑ None
- ❑ Moderate
- ❑ Daily
- ❑ Heavy

Work Activity
- ❑ Sitting
- ❑ Standing
- ❑ Light Labor
- ❑ Heavy Labor

Habits
- ❑ Smoking Packs/Day_____
- ❑ Alcohol Drinks/Week _____
- ❑ Coffee/Caffeine Drinks Cups/Day _____
- ❑ High Stress Level Reason _____

Surgeries (approx. dates):

_____

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