Initial History

Complete Entire Form **Please Print Clearly**

Name **DOB**

Last ***First*** ***MI.*** ***Age***

Chief Complaints/Problems: ____________________

____

____

Illnesses or Conditions

Do you now or have you ever had any of the following illnesses or conditions?
Explain any yes answers in comments section below.

	Y	N		Y	N		Y	N
Skin Problems	☐	☐	Heart Problems	☐	☐	Eye/Ear/Nose/Throat Problems	☐	☐
Yellow Jaundice	☐	☐	Heart Attack	☐	☐	Hearing Loss	☐	☐
Rashes/Hives	☐	☐	High Blood Pressure	☐	☐	Cataracts	☐	☐
Neurologic Problems	☐	☐	Heart Surgery	☐	☐	Glaucoma	☐	☐
Migraine Headaches	☐	☐	Rheumatic Fever	☐	☐	Sinusitis	☐	☐
Muscle Tension H/A's	☐	☐	Blood Clots	☐	☐	Lung Problems	☐	☐
Epilepsy	☐	☐	Leukemia	☐	☐	Asthma	☐	☐
Seizures	☐	☐	Anemia	☐	☐	Emphysema	☐	☐
Concussion	☐	☐	Stomach, Bowel Disorders	☐	☐	Pneumonia	☐	☐
Stroke	☐	☐	Ulcers	☐	☐	Tuberculosis	☐	☐
Polio	☐	☐	Gallstones	☐	☐	Diabetes	☐	☐
Spine Problems	☐	☐	Hernia	☐	☐	Thyroid Disease	☐	☐
Neck Pain	☐	☐	Liver disease	☐	☐	Cancer Specify ____________	☐	☐
Mid Back Pain	☐	☐	Hepatitis A, B, or C	☐	☐	____________________		
Lower Back Pain	☐	☐	Urinary Problems	☐	☐	Nervous or mental disorder	☐	☐
Bone, Joint Problems	☐	☐	Kidney Stone	☐	☐	Depression	☐	☐
Joint Pain	☐	☐	Kidney Disease	☐	☐	Anxiety	☐	☐
Arthritis/ Bursitis	☐	☐	Prostate Problems	☐	☐	Insomnia	☐	☐
Osteoporosis	☐	☐	Testicular Problems	☐	☐	Other Specify ____________	☐	☐
Gout	☐	☐	Gynecological problems	☐	☐	____________________		
Fractured Bones Specify	☐	☐	Sexual Dysfunction	☐	☐	____________________		
____________________			HIV/AIDS	☐	☐	____________________		

Comment: ____________________

____

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Review of Systems

Please check if you have any of the following

Fatigue	☐	Nasal Obstruction	☐	Nausea	☐	Joint Pain	☐
Chills	☐	Difficulty Swallowing	☐	Vomiting	☐	Joint Swelling	☐
Fever	☐	Cough	☐	Constipation	☐	Muscle Weakness	☐
Sweats	☐	Shortness of Breath	☐	Diarrhea	☐	Muscle Cramps	☐
Rash	☐	Chest Pain	☐	Unable to Control Bowels	☐	Numbness	☐
Headache	☐	Heart Palpitations	☐	Painful Urination	☐	Tingling	☐
Neck Stiffness	☐	Bruise Easily	☐	Difficulty Urinating	☐	Tremor	☐
Blurry Vision	☐	Excessive Bleeding	☐	Blood in Urine	☐	Weight Gain	☐
Ringing in Ears	☐	Irregular Heart Beat	☐	Unable to Control Bladder	☐	Weight Loss	☐
Sore Throat	☐	Abdominal Pain	☐	Backache	☐		

Do you take any prescription or over the counter medications? YES ☐ NO ☐
If yes please list:

Medication	Dosage	How Often
____________________	____________	____________
____________________	____________	____________

Name: ____________________ DOB: ____________

Are you allergic to any Medications YES ☐ NO ☐
If yes please list

Medication ____ Reaction ____

Have you ever been hospitalized or had surgery? YES ☐ NO ☐
If yes please list:

Date ____ Reason ____ Where ____

Family History
Please check if any of the listed family members have had any of the following problems:

	Father	Mother	Brothers or sisters	Spouse	Children	Grandparents
Allergies or asthma	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐
Bleeding tendencies	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Cancer or tumor	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Gout	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Kidney or bladder trouble	☐	☐	☐	☐	☐	☐
Stomach/duodenal ulcer	☐	☐	☐	☐	☐	☐
Nervous breakdown	☐	☐	☐	☐	☐	☐
Rheumatism or arthritis	☐	☐	☐	☐	☐	☐
Heart trouble	☐	☐	☐	☐	☐	☐

Vaccines, Immunizations, and Tests
Check vaccines/tests you have had. Enter the year you last were given the test or "shot."
For tests, circle if results were normal or abnormal

❏ Tetanus ____ ❏ Influenza ____
❏ Blood Sugar ____ normal abnormal ❏ Cholesterol ____ normal abnormal
❏ Chest x-ray ____ normal abnormal ❏ Electrocardiogram ____ normal abnormal
❏ GI series ____ normal abnormal ❏ Colon x-ray ____ normal abnormal
❏ Mammogram ____ normal abnormal ❏ Pap Smear ____ normal abnormal

Social History
Do you Smoke? YES ☐ NO ☐
If yes ____ cigarettes per day ____ Cigars per day/week ____ Number of years
Do you use other tobacco? YES ☐ NO ☐
If yes ____ Snuff ____ Chewing Tobacco ____ Number of years
Do you Drink? YES ☐ NO ☐
If yes
____ Beers per week ____ Glasses of wine per week ____ Mixed drinks per week
Please list your hobbies: ____________________

Do you exercise YES ☐ NO ☐
Describe: ____________________

Name: ____________________ DOB: ____________

Patient Signature ____________________ Date ____________ Reviewed by ____________