

5 Health History

Please tell us if there are any of the following Diseases in your immediate family, let us know who by putting suggested abbreviations on the appropriate line:

_____ Cancer (types of cancer?) _____	M=Mother	F=Father
_____ Diabetes	S=Sister	B=Brother
_____ Arthritis	A=Aunt	U=Uncle
_____ Heart Disease	GP=Grandparents	
_____ Other:		

Please check any conditions YOU presently have with #1 or have had in the past with #2

General	_____ Cancer (type)	_____ HIV	_____ Excess fatigue	_____ Fever/Chills	_____ Night sweats
EENT	_____ Allergy/sinus	_____ Vertigo	_____ Vision probs	_____ Hearing probs	_____ Speech probs
MS	_____ Neck pain	_____ Mid back	_____ Low back pain	_____ Osteoporosis	_____ Arthritis
	_____ Scoliosis	_____ Prosthesis	_____ Joint swelling	_____ Disc herniations	_____ Arch support/Heel lift
CRS	_____ High BP	_____ Heart attack	_____ Chronic cough	_____ Breathing probs	
	_____ Anemia	_____ Blockages	_____ High cholesterol	_____ TB	
GI	_____ Ulcers	_____ Hernia	_____ Appetite loss	_____ Anorexia	_____ Bowel/Bladder probs
GU	_____ Breast probs	_____ Abn. periods	_____ Abn. Pap Smear	_____ Urination probs	_____ Sexual Dysfunction
	_____ Kidney probs	_____ Prostate probs	_____ Testicular probs	_____ Menopause	_____ Pregnant/Due date
CNS/PNS	_____ Headache	_____ Seizures	_____ Fainting	_____ Epilepsy	_____ Dizziness/balance
	_____ Numbness	_____ Paralysis	_____ Memory probs	_____ Parkinson's	_____ Multiple Sclerosis
Endocrine	_____ Diabetes	_____ Hepatitis	_____ Thyroid probs	_____ Liver probs	_____ Excess thirst/urine/sweat
Vascular	_____ Stroke	_____ Clots	_____ Bleeding disorder	_____ Extremity coldness	
Psych	_____ Nervous	_____ Depression	_____ Moody/Irritable	_____ Suicide attempt	_____ Psych counseling
Other					

ANY significant Injuries/Surgeries/Tests: (not just what you feel is related to your present complaints)

Description	Approx. Dates
Significant Falls: _____	_____
Dislocations: _____	_____
Fractures/Broken Bones: _____	_____
Motor Vehicle Accidents: _____	_____
Surgeries: _____	_____
MRI, CAT scan, Bone scan: _____	_____
Other: _____	_____

Exercise	Work Activities	Social Habits
<input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy <input type="checkbox"/> Daily What Type?	<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor <input type="checkbox"/> Computer	<input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Coffee/Caffeine <input type="checkbox"/> High Stress levels Packs/Day: Drinks/Week: Cups/Day: Reason:

Sleep Habits	Medications	Vitamins/Minerals/Herbs
I average sleeping _____ hours per night Sleep: <input type="checkbox"/> Side <input type="checkbox"/> Back <input type="checkbox"/> Stomach <input type="checkbox"/> all-over Pillow Type: <input type="checkbox"/> Thin <input type="checkbox"/> Thick <input type="checkbox"/> Cervical Orthopedic Bed Type: <input type="checkbox"/> Mattress <input type="checkbox"/> Waterbed I sleep: <input type="checkbox"/> Well <input type="checkbox"/> Restless <input type="checkbox"/> Insomnia	<input type="checkbox"/> Pain Meds, Muscle Relaxers <input type="checkbox"/> Anti-inflammatories <input type="checkbox"/> OTC (Ibuprofen, etc.) <input type="checkbox"/> Other prescriptions <input type="checkbox"/> Birth Control <input type="checkbox"/> Insulin	<input type="checkbox"/> Multivitamin-mineral <input type="checkbox"/> Other: _____ _____ _____