

Patient History Form

Patient _____ Date _____

Childhood Diseases: Measles _____ Mumps _____ Chicken Pox _____ Others: _____

Unusual Childhood Diseases: _____

Adult Illnesses or Conditions: _____

Surgeries/Hospitalizations: _____

Fractures: _____

Medications _____

Are you allergic to any drugs or medications? _____

Last Physical (date) _____

Have you had or do you now have any of the following symptoms, which are or have been of significant distress to you? Please indicate with the letter N if you have these problems now or P if you have had these conditions previously.

N= Now

P=Previously

Headaches _____ Frequency _____	High Blood Pressure _____	Hands Cold _____
Neck Pain _____	Difficulty Urinating _____	Arthritis _____
Stiff Neck _____	Weakness in Extremities _____	Muscle Spasms _____
Sleeping Problems _____	Breathing Problems _____	Frequent Colds _____
Back Pain _____	Fatigue _____	Fever _____
Nervousness _____	Light Bother Eyes _____	Sinus Problems _____
Tension _____	Ears Ring _____	Diabetes _____
Irritability _____	Loss of Balance _____	Indigestions Problems _____
Chest Pains/Tightness _____	Fainting _____	Joint Pain/Swelling _____
Dizziness _____	Loss of Smell _____	Menstrual Difficulties _____
Shoulder/Neck/Arm Pain _____	Loss of Taste _____	Weight Loss/Gains _____
Numbness in Fingers _____	Unusual Bowel Problems _____	Depression _____
Numbness in Toes _____	Feet Cold _____	Loss of Memories _____
Buzzing in Ears _____	Women: Are you Pregnant: _____	

Please indicate beside each activity whether you engage in it:

OFTEN = O SOMETIMES= S NEVER=N

Vigorous Exercise _____

Moderate Exercise _____

Alcohol Use _____

Drug Use _____

Tobacco Use _____

Caffeine _____

High Stress Activity _____

Other Specify: _____