erlanger

HEALTH HISTORY

Date: _____

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All information is treated as strictly confidential. The more fully you complete this form, the better we will be able to diagnose and treat you.

Name: _____ **DOB:** _____ **Age:** _____

Office Use Only Temp _____ HR _____ BP_____ RR_____ Height_____ Weight_____ BMI_____

CHIEF COMPLAINT (Why are you seeing the doctor today?)

Chief Complaint: _____

_____

Location of Pain: □ Head □ Neck □ Back □ Other _____ Date Started: _____

Does the Pain extend into your □ **ARMS** or □ **LEGS**? □ Yes □ No

How bad is your pain on a scale of 1-10 (1 = minimal & 10 = worst) At its Best: _____ At its Worst: _____

What makes it - Better_____ Worse_____

Have you been treated with: □ Physical Therapy □ Chiropractor □ Pain Management □ NSAIDS (Advil/Aleve)

CURRENT AND PAST MEDICAL PROBLEMS

□ Hypertension □ Diabetes □ Osteoporosis _____

_____ _____

_____ _____

_____ _____

SURGERIES	YEAR	ANY COMPLICATIONS

MEDICAL ALLERGIES

_____

_____

ALLERGY SYMPTOMS

_____

_____

CURRENT MEDICATIONS (RX or OTC)

STRENGTH / DOSAGE (attach list for numerous meds)

Blood Thinner's? _____

SOCIAL HISTORY

Occupation: _____

Marital Status: □ Single □ Married □ Divorced □ Widow

Children: □ Yes □ No How Many? _____

Do you Smoke? □ Yes □ No □ Quit _____ how long □ Never Smoked

□ Cigarettes _____ packs per day for _____ year's □ Cigars/Pipe □ Smokeless Tobacco

Do you drink Alcohol? □ Never □ Rarely □ Socially □ Regularly

FAMILY HISTORY

	Alive	Age	Medical Problems
Father	□	____	_____
Mother	□	____	_____
Sister/Brother	□	____	_____
Sister/Brother	□	____	_____

Review of Systems

CHECK ALL THAT APPLY

Constitution
- Activity Change ☐
- Appetite Change ☐
- Fatigue ☐

Head/Ears/Nose/Throat
- Congestion ☐
- Dental Problems ☐
- Ear Pain ☐
- Facial Swelling ☐
- Hearing Loss ☐
- Tinnitus ☐
- Trouble Swallowing ☐

Eyes
- Photophobia ☐
- Visual disturbance ☐

Respiratory
- Apnea ☐
- Chest tightness ☐
- Cough ☐
- Shortness of Breath ☐
- Wheezing ☐

Heart
- Chest pain ☐
- Leg swelling ☐
- Palpitations ☐

GI
- Abdominal distention ☐
- Abdominal pain ☐
- Blood in stool ☐
- Nausea ☐
- Vomiting ☐

Endocrine
- Hot/Cold Intolerance ☐
- Excessive Thirst ☐

Urinary
- Difficulty urinating ☐
- Incontinence ☐

Muscular
- Joint pain ☐
- Gait problems ☐
- Neck pain ☐
- Neck stiffness ☐
- Back pain ☐

Skin
- Color change ☐
- Pallor ☐

Immune
- Immunocompromised ☐

Neurological
- Dizziness ☐
- Facial asymmetry ☐
- Headaches ☐
- Numbness ☐
- Seizures ☐
- Speech Difficulty ☐
- Syncope ☐
- Tremors ☐
- Weakness ☐

Hematologic
- Swollen lymph nodes ☐
- Easy Bleeding ☐

Psychiatric
- Confusion ☐

The above information is accurate to the best of my knowledge.

PATIENT SIGNATURE: _____ DATE: _____

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