



Health History Information

Name:

DOB:

Surgical History

Please list any past surgeries, and when they were done.

Medication

List any medications you are currently taking. Include the dosage.

Drug Allergies AND Their Reactions

List any drug allergies, or any bad reactions you have had to any medications. **Include the reaction.**

Pharmacy Information - DO NOT LEAVE BLANK

List **NAME** of pharmacy, its **LOCATION, ZIPCODE,** and **TELEPHONE** number.

Past Medical History - Please list any major medical problems you have had in the past.

Eye Problems:

ENMT (Ear, Nose, Mouth or Throat):

Cardiovascular or Pulmonary (Any problems with your heart, circulatory system, or lungs):

Genitourinary (Any reproductive or urinary system problems):

Musculoskeletal (Any problems with muscles, joints, bones, etc):

Neurological or Psychological:

Cancer:

Significant Injuries, or Complications with Anesthesia:

Skin, Endocrine, Hematologic, Lymphatic, Allergic, Immunologic Problems, or any other serious problems:

Social History

Please circle an answer, or fill in the blank.

| | | | | |
|--|---------------|---------------|----------------------|--------------|
| Hand Dominance: | Right | Left | Both | |
| Marital Status: | Single | Married | Divorced | Other: _____ |
| Highest Education Level: | HS (grade 12) | College (4yr) | Post-Grad | Other: _____ |
| Who referred you to us? | _____ | | | |
| Who is your Primary Care Physician? | _____ | | | |
| Do you drink alcohol? | Never | Occasionally | Moderately | Heavily |
| Do you smoke? If yes, how much? | No | Yes: _____ | Packs Per Day: _____ | |
| Do you chew tobacco? If yes, how much? | No | Yes: _____ | | |
| Do you use any illicit drugs? If yes, which? | No | Yes: _____ | | |
| Who is your employer? | _____ | | | |
| What is your occupation? | _____ | | | |
| Were you injured on the job? | No | Yes | | |
| Is there or will there be litigation? | No | Yes | | |
| Were you injured in an auto accident? | No | Yes | | |

Family History

Tell us about any family members who have or have had major health problems which could affect you.

Mother

Father

Siblings

Other

If you are 65 or over:

Have you fallen two or more times which resulted in an injury?

Have you fallen but were not injured?