

# HEALTH HISTORY INFORMATION

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Have you been treated for any health condition by a physician in the past year? Yes \_\_\_ No \_\_\_

If Yes, what condition? \_\_\_\_\_

Are you seeing any other doctor now for any reason? Yes \_\_\_ No \_\_\_

Note: \_\_\_\_\_

Are you using birth control pills? Yes \_\_\_ No \_\_\_

If Yes, indicate type (YAZ, Orthonova, etc.) \_\_\_\_\_

Are you taking any medications or over-the-counter drugs? Yes \_\_\_ No \_\_\_

Please indicate type (aspirin, etc.) \_\_\_\_\_

Are you taking any vitamins or mineral supplements? Yes \_\_\_ No \_\_\_ Which ones (Vitamin C, Multiple, etc.) \_\_\_\_\_

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**Have you had or do you now have any of the following symptoms, which are or have been of significant distress to you?**

Have you lost or gained weight in the past year? Yes \_\_\_ No \_\_\_

Have you ever had cancer? Yes \_\_\_ No \_\_\_

Does your pain ever wake you from a sound sleep? Yes \_\_\_ No \_\_\_

Are you losing weight now without trying? Yes \_\_\_ No \_\_\_

Are you coughing up blood or noticing it in your stools or urine? Yes \_\_\_ No \_\_\_

Have you had any loss of bladder or bowel control? Yes \_\_\_ No \_\_\_

Have you lost consciousness or had double vision recently? Yes \_\_\_ No \_\_\_

What was the date of onset of your last menses (period)? \_\_\_\_\_

Do you have any change in bowel or bladder habits? Yes \_\_\_ No \_\_\_

Do you have a sore that does not heal? Yes \_\_\_ No \_\_\_

Do you have any unusual bleeding or discharge? Yes \_\_\_ No \_\_\_

Do you have indigestion or difficulty in swallowing? Yes \_\_\_ No \_\_\_

Do you have any thickening in your breast or elsewhere? Yes \_\_\_ No \_\_\_

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HEALTH HISTORY INFORMATION: Continued:

**Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

- Do you have a change in any wart or mole? Yes \_\_\_ No \_\_\_
- Do you have a nagging cough or hoarseness? Yes \_\_\_ No \_\_\_
- Do you have blurred vision? Yes \_\_\_ No \_\_\_
- Do you have night sweats/Hot Flashes? Yes \_\_\_ No \_\_\_
- Do you have a drooping eyelid or any change in your pupils? Yes \_\_\_ No \_\_\_
- Do you have any visual disturbances? Yes \_\_\_ No \_\_\_
- Do you have any slurred speech? Yes \_\_\_ No \_\_\_

**Please indicate with the letter N if you have these conditions now (within the past 12 months)  
or P if you ever had this condition in the past.**

	<b>Now</b>	<b>Past</b>		<b>Now</b>	<b>Past</b>
Headaches	_____	_____	Frequent Loss of Balance	_____	_____
Neck Pain	_____	_____	Fainting	_____	_____
Stiff Neck	_____	_____	Loss of Smell	_____	_____
Problems Sleeping	_____	_____	Loss of Taste	_____	_____
Back Pain	_____	_____	Diarrhea/Colitis	_____	_____
Nervousness	_____	_____	Feet Cold	_____	_____
Tension	_____	_____	Hands Cold	_____	_____
Irritability	_____	_____	Arthritis	_____	_____
Chest Pains	_____	_____	Muscle Spasms	_____	_____
Dizziness	_____	_____	Frequent Colds	_____	_____
Shoulder/Arm Pain	_____	_____	Stomach Upset	_____	_____
Pins & Needles in Arms	_____	_____	Constipation	_____	_____
Pins & Needles in Legs	_____	_____	Cold Sweats	_____	_____
Numbness in Fingers	_____	_____	Fever	_____	_____
Numbness in Toes	_____	_____	Sinus Problems	_____	_____
High Blood Pressure	_____	_____	Diabetes	_____	_____
Difficulty Urinating	_____	_____	Hemorrhoids	_____	_____
Allergies	_____	_____	Leg Cramps	_____	_____
Weakness in Arms/Legs	_____	_____	Gall Bladder	_____	_____
Shortness of Breath	_____	_____	Menstrual Difficulties	_____	_____
Fatigue	_____	_____	Belching	_____	_____
Depression	_____	_____	Vomiting	_____	_____
Lights Bother Eyes	_____	_____	Shoulder Pain	_____	_____
Loss of Memory	_____	_____	Swelling in Joints	_____	_____
Ears Ring or Buzz	_____	_____	Knee Pain	_____	_____
Face Flushes	_____	_____	Hay Fever	_____	_____

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HEALTH HISTORY INFORMATION: Continued

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Family History

Did your mother or father have any of the following? Circle M =mother, F for father, B = Both, N=No

- (M / F/ B/ N) Asthma (M / F/ B/ N) Arthritis-Rheumatism (M / F/ B/ N) Cancer
(M / F/ B/ N) Circulation Problems (M / F/ B/ N) Diabetes (M / F/ B/ N) Emphysema
(M / F/ B/ N) High Blood Pressure (M / F/ B/ N) Heart Attack (M / F/ B/ N) HIV Positive
(M / F/ B/ N) Kidney Disease (M / F/ B/ N) Mental Illness (M / F/ B/ N) Osteoporosis
(M / F/ B/ N) Pacemaker (M / F/ B/ N) Seizures-Convulsions (M / F/ B/ N) Stroke
(M / F/ B/ N) Thyroid Disease (M / F/ B/ N) Ulcer or Stomach Problems

Is there any part of your health history or issues that we have not asked about? \_\_\_ No, you've covered all the health issues I have.

\_\_\_ Yes, I am concerned specifically about this:

SIGNED: \_\_\_\_\_

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ADDITIONAL NOTES BY INTERVIEWER:

INTERVIEWED BY: \_\_\_\_\_

Moraine Valley Chiropractic Center