HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Date: ____________________

Patient Name ____ Birthdate ____________ Patient # ____________________

Chief Complaint: ____

History of present illness:

Location: ________________________________
(Where is the pain/problem?)

Quality ________________________________
(Example: normal versus abnormal color, activity, etc.)

Severity ________________________________
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

Duration ________________________________
(How long have you had this pain/problem?, or, When did it start?)

Timing ________________________________
(Does the pain/problem occur at a specific time?)

Context ________________________________
(Where were you at the onset of this pain/problem?)

Associated signs/symptoms ________________________________
____
(What other associated problems have you been having?)

Modifying factors ________________________________
____
(What makes the pain/problem worse or better?, or, Have you had previous episodes?)

Past Medical History
Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	Anemia	no	yes	Back trouble	no	yes	Hepatitis	no	yes
Mumps	no	yes	Bladder Infections	no	yes	High Blood Pressure	no	yes	Ulcer	no	yes
Chickenpox	no	yes	Epilepsy	no	yes	Low Blood Pressure	no	yes	Kidney Disease	no	yes
Whooping Cough	no	yes	Migraine Headaches	no	yes	Hemorrhoids	no	yes	Thyroid Disease	no	yes
Scarlet Fever	no	yes	Tuberculosis	no	yes	Date of last chest x-ray ________			Bleeding Tendency	no	yes
Diphtheria	no	yes	Diabetes	no	yes	Asthma	no	yes	Any other disease	no	yes
Smallpox	no	yes	Cancer	no	yes	Hives or Eczema	no	yes	(please list):		
Pneumonia	no	yes	Polio	no	yes	AIDS or HIV+	no	yes	________		
Rheumatic Fever	no	yes	Glaucoma	no	yes	Infectious Mono	no	yes	________		
Heart Disease	no	yes	Hernia	no	yes	Bronchitis	no	yes	________		
Arthritis	no	yes	Blood or Plasma			Mitral Valve Prolapse	no	yes	________		
Venereal Disease	no	yes	Transfusions	no	yes	Stroke	no	yes	________		

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

________________________ ________ ________________________
________________________ ________ ________________________
________________________ ________ ________________________

Medications: (Include nonprescription) ____
____
____

Patient social history:

Marital status	Single: ____	Married: ____	Separated: ____	Divorced: ____	Widowed: ____
Use of alcohol:	Never: ____	Rarely: ____	Moderate: ____	Daily: ____	
Use of tobacco:	Never: ____	Previously, but	quit: ____	Current packs / day: ____	
Use of drugs:	Never: ____	Type/Frequency:	________________		
Excessive exposure at home or work to:	Fumes: ____	Dust: ____	Solvents: ____	Air-borne Particles: ____	Noise: ____

Family medical history:

	Age	Diseases	If Deceased, Cause of Death
Father	____	________________	________________
Mother	____	________________	________________
Siblings	____	________________	________________
	____	________________	________________
	____	________________	________________
Spouse	____	________________	________________
Children	____	________________	________________
	____	________________	________________
	____	________________	________________

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Review of Systems: Please indicate any personal history below:

☐ **Constitutional Symptoms**
- Good general health lately . . . . . No Yes
- Recent weight change . . . . No Yes
- Fever . . . . No Yes
- Fatigue . . . . No Yes
- Headaches . . . . No Yes

☐ **Eyes**
- Eye disease or injury . . . . No Yes
- Wear glasses/contact lenses . . . . No Yes
- Blurred or double vision. . . . . . . No Yes

☐ **Ears/Nose/Mouth/Throat**
- Hearing loss or ringing . . . . No Yes
- Earaches or drainage . . . . No Yes
- Chronic sinus problem or rhinitis . No Yes
- Nose bleeds. . . . . No Yes
- Mouth sores. . . . . No Yes
- Bleeding gums . . . . No Yes
- Bad breath or bad taste . . . . No Yes
- Sore throat or voice change . . . . No Yes
- Swollen glands in neck. . . . . No Yes

☐ **Cardiovascular**
- Heart trouble. . . . . No Yes
- Chest pain or angina pectoris . . . No Yes
- Palpitation . . . . No Yes
- Shortness of breath w/walking or lying flat. . . . . No Yes
- Swelling of feet, ankles or hands. No Yes

☐ **Respiratory**
- Chronic or frequent coughs . . . . No Yes
- Spitting up blood . . . . No Yes
- Shortness of breath . . . . No Yes
- Wheezing . . . . No Yes

☐ **Gastrointestinal**
- Loss of appetite . . . . No Yes
- Change in bowel movements . . . No Yes
- Nausea or vomiting . . . . No Yes
- Frequent diarrhea . . . . No Yes
- Painful bowel movements or constipation. . . . . No Yes
- Rectal bleeding or blood in stool No Yes
- Abdominal pain . . . . No Yes

☐ **Genitourinary**
- Frequent urination . . . . No Yes
- Burning or painful urination . . . No Yes
- Blood in urine. . . . . No Yes
- Change in force of strain when urinating . . . . No Yes
- Incontinence or dribbling . . . . . No Yes
- Kidney stones . . . . No Yes
- Sexual difficulty. . . . . No Yes
- Male - testicle pain . . . . No Yes
- Female - pain with periods . . . . No Yes
- Female - irregular periods . . . . . No Yes
- Female - vaginal discharge . . . . No Yes
- Female - # of pregnancies . . . ________
- Female - # of miscarriages . . . ________
- Female - date of last pap smear ________

☐ **Musculoskeletal**
- Joint pain . . . . No Yes
- Joint stiffness or swelling . . . . . . No Yes
- Weakness of muscles or joints . . No Yes
- Muscle pain or cramps . . . . No Yes
- Back pain . . . . No Yes
- Cold extremities . . . . No Yes
- Difficulty in walking . . . . No Yes

☐ **Integumentary (skin, breast)**
- Rash or itching . . . . No Yes
- Change in skin color . . . . No Yes
- Change in hair or nails . . . . No Yes
- Varicose veins. . . . . No Yes
- Breast pain . . . . No Yes
- Breast lump . . . . No Yes
- Breast discharge . . . . No Yes

☐ **Neurological**
- Frequent or recurring headaches No Yes
- Light headed or dizzy . . . . No Yes
- Convulsions or seizures . . . . No Yes
- Numbness or tingling sensations No Yes
- Tremors . . . . No Yes
- Paralysis . . . . No Yes
- Head injury . . . . No Yes

☐ **Psychiatric**
- Memory loss or confusion . . . . . No Yes
- Nervousness. . . . . No Yes
- Depression. . . . . No Yes
- Insomnia . . . . No Yes

☐ **Endocrine**
- Glandular or hormone problem . No Yes
- Excessive thirst or urination . . . . No Yes
- Heat or cold intolerance. . . . . . . No Yes
- Skin becoming dryer . . . . No Yes
- Change in hat or glove size. . . . . No Yes

☐ **Hematologic/Lymphatic**
- Slow to heal after cuts . . . . No Yes
- Bleeding or bruising tendency . . No Yes
- Anemia . . . . No Yes
- Phlebitis. . . . . No Yes
- Past transfusion . . . . No Yes
- Enlarged glands . . . . No Yes

☐ **Allergic/Immunologic**

History of skin reaction or other adverse reaction to:
- Penicillin or other antibiotics . . No Yes
- Morphine, Demerol, or other narcotics . . . . No Yes
- Novocain or other anesthetics . No Yes
- Aspirin or other pain remedies No Yes
- Tetanus antitoxin or other serums. . . . . No Yes
- Iodine, Merthiolate or other antiseptic. . . . . No Yes
- Other drugs/medications: ____________

____

Known food allergies: ________________

____

Environmental allergies: ______________

____

To the best of my knowlege, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibilty to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

____ ____________________

Signature of Parent or Guardian Date

Doctor's Review

____ ____________________

Signature of Doctor Date

AQUIA FAMILY CHIROPRACTIC CTR