Case History

Please answer the questions below concerning your health history. List all conditions or symptoms, both past and present. An understanding of your health history will help us to determine appropriate care.

NAME _____ DATE _____

Review of Systems

1. Do you have skin, hair or nail problems: O Yes O No _____
2. Do you have mouth and/or throat problems? O Yes O No _____
3. Do you have nose and/or sinus problems? O Yes O No _____
4. Do you have ear problems? O Yes O No _____
5. Do you have eye problems? O Yes O No _____
6. Do you have chest or lung (breathing) problems? O Yes O No _____
7. Do you smoke? O Yes O No Amount per day How Long? _____
8. Do you have heart and/or blood vessel problems? O Yes O No _____
9. Do you have blood or lymph node problems? O Yes O No _____
10. Do you have digestive problems? O Yes O No _____
11. Do you have genital problems (e.g. prostate, testicular, vaginal)? O Yes O No _____
12. Do you have urinary (including kidney or bladder) problems? O Yes O No _____
13. **Females**, have you had menstrual problems? O Yes O No _____

Is there any chance that you are currently pregnant? O Yes O No _____

Do you have any breast problems? O Yes O No _____

14. Do you have any nervous system diseases and/or mental health problems? O Yes O No _____
15. Do you have any gland and/or hormone problems? O Yes O No _____
16. Do you have allergy or immunity problems? O Yes O No _____
17. Do you have any muscle, tendon or ligament problems? O Yes O No _____
18. Do you have any bone or joint diseases (examples: bone = osteoporosis, joint = arthritis)? O Yes O No _____

Past History

19. List any diseases which you have had in the past:

20. Tell us if you have ever been diagnosed as having a particular condition such as diabetes, cancer, AIDS, etc.:

21. Have you suffered any physical injuries such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones? O Yes O No

22. List any major surgeries you have had:

	Date
	Date
_____	Date _____
_____	Date _____
_____	_____
_____	_____

Case History
(Continued)

NAME _____ DATE _____

23. Have you ever been hospitalized for any reason other than surgery? O Yes O No
24. Medications: Please list all medications (prescription & non-prescription) you are currently taking or take on an occasional basis:
25. Your diet is: O Balanced O Fair
    Family History O Poor O Excessive O Restricted
26. Are there any diseases or conditions that are common among your family members (i.e. inherited diseases or conditions)? O Yes O No

Social History

27. In what position do you usually sleep, and how well? _____
28. Do you exercise on a regular basis? O Yes O No How? _____
29. How do you spend your spare time (hobbies, etc.)? _____
30. Do you use: O Caffeine? O Tobacco? O Nicotine? O Recreational Drugs? O Alcohol?
31. Please describe your work.

Type: O Professional O Physical Labor O Driver O Clerical O Factory O Homemaker
Physical Demands: O Heavy O Moderate O Mild O Sedentary
Stress Level: O High O Medium O Low

Additional Questions

32. Do you have problems with recurring headaches? O Yes O No
33. Are you losing weight without trying? O Yes O No
34. Does your pain wake you up at night? O Yes O No
35. Have you had a change in bowel or bladder habits? O Yes O No
36. Have you had a sore that doesn't heal? O Yes O No
37. Have you recently had any unusual bleeding or discharge? O Yes O No
38. Do you have a thickening/lump in the breast or elsewhere? O Yes O No
39. Do you have indigestion or difficulty swallowing? O Yes O No
40. Have you had an obvious change in a wart or mole? O Yes O No
41. Do you have a nagging cough or hoarseness? O Yes O No
42. In the space below, please explain or give additional details regarding the information you have given above. Also, if there is any information about your health history which was not requested, please fill it in below.

_____

_____