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 N0 _____
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 _____
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: _____

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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 O Poor O Excessive O Restricted

Family History

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.

_____
_____
_____