Patient's Full Name: ____________________ **Date of Birth** ______________

Health History Form

Prescription Medications:

Medication: ________________ Dosage _____Frequency: per __day __week __month
Other (please describe): __________________
Medication: ________________ Dosage _____Frequency: per __day __week __month
Other (please describe): __________________
Medication: ________________ Dosage _____Frequency: per __day __week __month
Other (please describe): __________________
Medication: ________________ Dosage _____Frequency: per __day __week __month
Other (please describe): __________________
Medication: ________________ Dosage _____Frequency: per __day __week __month
Other (please describe): __________________
Medication: ________________ Dosage _____Frequency: per __day __week __month
Other (please describe): __________________
Medication: ________________ Dosage _____Frequency: per __day __week __month
Other (please describe): __________________
Medication: ________________ Dosage _____Frequency: per __day __week __month
Other (please describe): __________________
Medication: ________________ Dosage _____Frequency: per __day __week __month
Other (please describe): __________________
Medication: ________________ Dosage _____Frequency: per __day __week __month
Other (please describe): __________________

Over the Counter Medication:

Medication: ________________ Dosage _____Frequency: per __day __week __month
Other (please describe): __________________
Medication: ________________ Dosage _____Frequency: per __day __week __month
Other (please describe): __________________
Medication: ________________ Dosage _____Frequency: per __day __week __month
Other (please describe): __________________
Medication: ________________ Dosage _____Frequency: per __day __week __month
Other (please describe): __________________
Medication: ________________ Dosage _____Frequency: per __day __week __month
Other (please describe): __________________
Medication: ________________ Dosage _____Frequency: per __day __week __month
Other (please describe): __________________
Medication: ________________ Dosage _____Frequency: per __day __week __month
Other (please describe): __________________
Medication: ________________ Dosage _____Frequency: per __day __week __month
Other (please describe): __________________

Vitamins, Minerals, Herbs, or Dietary Supplements

Supplement: ____________________Dosage ____ Frequency: per __day __week __ month
Other (please describe): ____________________

Supplement: ____________________Dosage ____ Frequency: per __day __week __ month
Other (please describe): ____________________

Supplement: ____________________Dosage ____ Frequency: per __day __week __ month
Other (please describe): ____________________

Supplement: ____________________Dosage ____ Frequency: per __day __week __ month
Other (please describe): ____________________

Supplement: ____________________Dosage ____ Frequency: per __day __week __ month
Other (please describe): ____________________

Supplement: ____________________Dosage ____ Frequency: per __day __week __ month
Other (please describe): ____________________

Supplement: ____________________Dosage ____ Frequency: per __day __week __ month
Other (please describe): ____________________

Supplement: ____________________Dosage ____ Frequency: per __day __week __ month
Other (please describe): ____________________

Supplement: ____________________Dosage ____ Frequency: per __day __week __ month
Other (please describe): ____________________

Supplement: ____________________Dosage ____ Frequency: per __day __week __ month
Other (please describe): ____________________

Supplement: ____________________Dosage ____ Frequency: per __day __week __ month
Other (please describe): ____________________

Supplement: ____________________Dosage ____ Frequency: per __day __week __ month
Other (please describe): ____________________

Diet and Exercise

Have you ever smoked cigars? _____yes ___ no

Do you still smoke? _____ yes ____ no

How much do you smoke? _____ Less than one pack per week _____ 1-2 packs per week

_____ 1 pack every two days _____ 1 pack per day ___ more than one pack per day

Do you drink alcoholic beverages _____yes _____ no

How many alcoholic beverages do you consume per week? ______

Has a physician has ever diagnosed you as an alcoholic? ______ yes ______ no

Has a physician ever diagnosed you with any liver-related problems? _____yes _____ no

Do you exercise regularly? _____ yes _____ no

How many days do you exercise each week? __________

Family Cancer History

Check if a physician has ever diagnosed your family with cancer. ____ yes

Check all that apply and the family member(s) who has this condition:
M – Mother F – Father S – Sibling MG – Maternal Grandparent PG – Paternal Grandparent

___ Bladder (M, F, S, MG, PG)
___ Brain (M, F, S, MG, PG)
___ Breast (M, F, S, MG, PG)
___ Cervical (M, F, S, MG, PG)
___ Colon or Rectal (M, F, S, MG, PG)
___ Endometrial (M, F, S, MG, PG)
___ Eye (M, F, S, MG, PG)
___ Kidney (M, F, S, MG, PG)
___ Leukemia (M, F, S, MG, PG)
___ Other _____ (M, F, S, MG, PG)
___ Stomach (M, F, S, MG, PG)
___ Uterine (M, F, S, MG, PG)
___ Lung (M, F, S, MG, PG)
___ Non Hodgkin's Lymphoma (M, F, S, MG, PG)
___ Ovarian (M, F, S, MG, PG)
___ Pancreatic (M, F, S, MG, PG)
___ Prostate (M, F, S, MG, PG)
___ Skin (M, F, S, MG, PG)
___ Basal Cell Carcinoma (M, F, S, MG, PG)
____ Squamous Cell Carcinoma (M, F, S, MG, PG)
___ Melanoma (M, F, S, MG, PG)
___ Thyroud (M, F, S, MG, PG)

Your Cardio-pulmonary/Circulatory Health

Check if a physician has ever diagnosed you with any of the following:
___ Anemia ___ HIV/Aids ___ Hemphilia ___ Hepatitis
___ Hypertension (high blood pressure) ___ Hypotension (low blood pressure)
___ Hemorrhoids ___ Raynaud's Phenomeonon ___ Sickle cell anemia
___ Sinus Infections (chronic) ___ Stroke ___ Wegener's Granulomatosis
___ Other _____
___ Lung Disorders:
___ Acute Respiratory Distress Syndrome
___ Asthma
___ Bronchitis (chronic)
___ Chronic Obstructive Pulmonary Disease
___ Famer's Lung
___ Hentavirus
___ Legionellosis
___ Pleurisy
___ Pneumothorax
___ Pulmonary Alveolar Proteinosis
___ Pulmonary Fibrosis
___ Respiratory Syncytial Virus
___ Severe Acute Respiratory Syndrome
___ Tuberculosis
___ Alpha-1 Antitrypsin Deficiency
___ Asbestos/Dust/Disease
___ Bronchiectasis
___ Cystic Fibrosis
___ Emphysema
___ Histoplasmosis
___ Lymphangioleiomyomatosis
___ Pneumonia
___ Primary Alveolar Hypoventilation Syndrome
___ Pulmonary Embolus
___ Respiratory Distress Syndrome
___ Sarcoidosis
___ Spontaneous Pneumothorax

Family Cardio-pulmonary/Circulatory Health

Check if a physician has ever diagnosed your family with any of the following:

___ Anemia (M, F, S, MG, PG) ___ HIV/Aids (M, F, S, MG, PG)
___ Hemphilia (M, F, S, MG, PG) ___ Hepatitis (M, F, S, MG, PG)
___ Hypertension (high blood pressure (M, F, S, MG, PG)
___ Hypotension (low blood pressure) (M, F, S, MG, PG)
___ Hemorrhoids (M, F, S, MG, PG) ___ Raynaud's Phenomenon (M, F, S, MG, PG)
___ Sickle cell anemia (M, F, S, MG, PG) ___ Sinus Infections (chronic) (M, F, S, MG, PG)
___ Stroke (M, F, S, MG, PG) ___ Wegener's Granulomatosis (M, F, S, MG, PG)
___ Other _____ (M, F, S, MG, PG)
___ Lung Disorders:
- ___ Acute Respiratory Distress Syndrome (M, F, S, MG, PG)
- ___ Alpha-1 Antitrypsin Deficiency (M, F, S, MG, PG)
- ___ Asthma (M, F, S, MG, PG)
- ___ Asbestos/Dust/Disease (M, F, S, MG, PG)
- ___ Bronchitis (chronic) (M, F, S, MG, PG)
- ___ Bronchiectasis (M, F, S, MG, PG)
- ___ Chronic Obstructive Pulmonary Disease (M, F, S, MG, PG)
- ___ Cystic Fibrosis (M, F, S, MG, PG)
- ___ Famer's Lung (M, F, S, MG, PG)
- ___ Emphysema (M, F, S, MG, PG)
- ___ Hentavirus (M, F, S, MG, PG)
- ___ Histoplasmosis (M, F, S, MG, PG)
- ___ Legionellosis (M, F, S, MG, PG)
- ___ Lymphangioleiomyomatosis (M, F, S, MG, PG)
- ___ Pleurisy (M, F, S, MG, PG)
- ___ Pneumonia (M, F, S, MG, PG)
- ___ Pneumothorax (M, F, S, MG, PG)
- ___ Primary Alveolar Hypoventilation Syndrome (M, F, S, MG, PG)
- ___ Pulmonary Alveolar Proteinosis (M, F, S, MG, PG)
- ___ Pulmonary Embolus (M, F, S, MG, PG)
- ___ Pulmonary Fibrosis (M, F, S, MG, PG)
- ___ Respiratory Distress Syndrome (M, F, S, MG, PG)
- ___ Respiratory Syncytial Virus (M, F, S, MG, PG)
- ___ Sarcoidosis (M, F, S, MG, PG)
- ___ Severe Acute Respiratory Syndrome (M, F, S, MG, PG)
- ___ Spontaneous Pneumothorax (M, F, S, MG, PG)
- ___ Tuberculosis (M, F, S, MG, PG)

Surgical History

Do you have any implants, screws, plates, or other foreign objects in your body? ___ yes ___ no
___ Bullet wound(s) ___ Infusion Catheter ___ Ear Implant ___ Pacemakers
___ Eye implant ___Brain Plate(s) ___ Heart Valve(s) ___ Shrapnel ___ Other _____

Musculoskeletal Surgeries (check if you have had any of the following surgeries)
___ Ankle Year(s) of surgery _____ ___Head Year(s) of surgery _____
___ Back Year(s) of surgery _____ ___ Hip Year(s) of surgery _____
___ Cosmetic or Augmentation Year(s) of surgery _____
___ Knee Year(s) of surgery _____
___ Elbow Year(s) of surgery _____ ___ Neck Year(s) of surgery _____
___ Foot Year(s) of surgery _____ ___ Shoulder Year(s) of surgery _____
___ Hand Year(s) of surgery _____ ___ Wrist Year(s) of surgery _____
___ Other (please describe) _____

Organ System Surgeries (Check if you have had any of the following surgeries_
___ Brain Year(s) of surgery _____ ___ Large Intestine Year(s) of surgery _____
___ Colon Year(s) of surgery _____ ___ Liver Year(s) of surgery _____
___ Esophagus Year(s) of surgery _____ ___ Lung Year(s) of surgery _____
___ Eye Year(s) of surgery _____ ___ Mastectomy Year(s) of surgery _____
___ Heart Year(s) of surgery _____
___Reproductive Organs Year(s) of surgery _____
___ Kidney Year(s) of surgery _____ ___ Skin Year(s) of surgery _____
___ Intestine, small Year(s) of surgery _____ ___Throat Year(s) of surgery _____
___ Other please describe _____ Year(s) of surgery _____
___ Transplant please describe _____ Year(s) of surgery _____

Your Cancer History:

Check if a physician has ever diagnosed you with cancer: ____ yes
Check all that apply:
___ Bladder ___ Lung ___ Brain ___ Non-Hodgkin's Lyphoma ___ Breast
___ Ovarian ___ Cervical ___ Pancreatic ___ Colon or Rectal ___ Prostate
___ Endometrial ___ Skin ___ Eye ___ Basal Cell Carcinoma ___ Kidney (renal cell)
___ Squamous Cell Carcinoma ___ Leukemia ___ Melanoma ___ Other _____
___ Stomach ___ Thyroid ___ Uterine

Endocrine, Gastrointestinal and Neurologic Health

Check if a physician has ever diagnosed you with any of the following:

___Autoimmune disorder
- ___ Dermatitis
- ___ Eosinophillic Fasciitis
- ___ Goodpasture's Syndrome
- ___ Lupus:
  - ___ Lupus SLE ___Lupus DLE ___Lupus SCLE
  - ___ Anti-Phospholipid Antibody Syndrome (Lupus Anticoagulant)
- ___ Mixed Connective Tissue Disease
- ___ Rheumatoid Arthritis
- ___ Scleroderma
- ___ Skin Immunoflurescence
- ___ Churg – Strauss (Allergic Granulomatosis)
- ___ Dermatomyositis/Polymyositis
- ___ Interstitial Granulomatous Dermatitis with Arthritis
- ___ Relapsing Polychondritis
- ___ Sarcoidosis
- ___ Sjogren's Syndrome
- ___ Vasculitis

___ Bladder Disease
___ Chicken Pox
___ Crohn's Disease
___ Epilepsy
___ Gall Bladder Problems
___ Headaches:
- ___ Cluster headaches
- ___ Sinus headaches
- ___ Tension headaches
- ___ Migraine headaches
- ___ Stress-induced headaches

___ Incontinence
___ Kidney Disease
___ Liver Problems
___ Mumps
___ Shingles
___ Thyroid Dysfunction
___ Other _____
___ Candida
___ Chronic Fatigue Syndrome
___ Diabetes
___ Fibromyalgia
___ Irritable Bowel Syndrome
___ Liver Disease
___ Measles
___ Seizures
___ Stomach Ulcers
___ Urinary Tract Infections

Emotional Health

Check if a physician has ever diagnosed you with an emotional or mental condition: ____yes

____ Anger Disorders ____ Anxiety Disorders
____ Asperger Syndrome ____ Attention Deficit Disorder with Hyperactivity (ADHD)
____ Autistic Disorder ____ Avoidant Personality Disorder (AvPD)
____ Bipolar Disorder ____ Borderline Personality Disorder
____ Capgrass Syndrome ____ Child Behavior Disorders
____ Combat Disorders ____ Cyclothymic Disorder
____ Dependent Personality Disorder ____ Depressive Disorders (depression)
____ Dissociative Disorders ____ Dysthymic Disorders (mood disorder)
____ Eating Disorders ____ Firesetting Behavior
____ Hypochondriasis (Somatoform Disorder) ____ Impulse Control Disorder
____ Kleine-Levin Syndrome ____ Kleptomania
____ Multiple Personality Disorder ____ Munchhausen Syndrome
____ Obsessive Compulsive Disorder (OCD) ____ Phobic Disorders (phobias)
____ Psychotic Disorders ____ Restless Legs Syndrome
____ Schizophrenia ____ Seasonal Affective Disorder
____ Sexual or Gender Disorders ____ Sexual Dysfunctions (psychological, not physical)
____ Sleep Disorders ____ Post-traumatic Stress Syndrome
____ Substance Abuse ____ Suicidal Tendencies
____ Other _____

Sensory Health

Check if a physician has ever diagnosed you with any of the following:

____Blindness ____ Cataract ____ Cholesteatoma ___ Deafness or Hearing loss
___ Ear ringing ____ Eczema ___ Glaucoma ___ Laryngitis (chronic)
___ Macular Degeneration ___ Mumps ___ Meniere's Disease ___ Nasal Polyps
___ Perforated Ear Drum ___ Psoriasis ___ Rhinitis ___ Sinusitis ___ Tinnitus
___ Unusual Vision Impairment ___ Vertigo ___ Other _____

Musculoskeletal Health

Check if a physician has ever diagnosed you with any of the following:

___ Arthritis:
- ___ Ankylosing Spondylitis
- ___ Carpal Tunnel Syndrome
- ___ Ehlers-Danios Syndrome (EDS)
- ___ Fibromyalgia
- ___ Mixed Connective4 Tissue Disease (MCTD)
- ___ Osteoporosis
- ___ Polymyalgia Rheumatica
- ___ Polymyositis and Dermatomyositis
- ___ Reactive Arthritis
- ___ Rheumatoid Arthritis
- ___ Sjogren's Syndrome
- ____ Behets Disease
- ____ Diffuse Idiopathic Skeletal Hyperostosis (DISH)
- ____ Felty's Syndrome
- ____ Infectious Arthritis
- ____ Osteoarthritis
- ___ Paget's Disease
- ___ Pseudogout
- ____ Psoriatic Arthritis
- ____ Repetitive Stress Injury
- ____ Scleroderma
- ____ Stills Disease

___ Gout ___Herniated Disc ___Lyme Disease ___ Multiple Sclerosis
___ Muscular Dystrophy ___ Numbness or tingling in feet ___ Numbness or tingling in hands
___ Osteoporosis ___ Parkinson's Disease ___ Pinched Nerve ___ Polio ___ Rheumatism
___ Sciatica ___ Temporomandibular Joint Syndrome (TMJ)
___ Other _____

Reproductive Health

Check if you have ever given birth: ____ yes
How many vaginal births? _____
How many by C-section? _____

Check if a physician has ever diagnosed you with any of the following:

___ Chlamydia ___ Dysplasia ___ Erectile Dysfunction ___ Genital Herpes
___ Gonorrhea ___ Human Papillomavirus (HPV) ___ Impotency ___ Syphilis
___ Infertility ___ Cystitis ___ Menopause ___ Prostate Enlargement
___ Testicular Dysfunction ___ Uterine Fibroid ___ Vaginal Yeast Infections (chronic)
___ Other _____

Allergies

Have you ever been diagnosed with any allergies? ____ yes ____ no

Do you have Airborne allergies? ____ yes ____ no

___ Animal ___ Molds/Fungus ___ Pollens ___ Other _____

___ Cat Hair ___ Cockroach ___ Dog Hair ___ Feather Max

___ Guinea Pig Hair ___ Dust Mites

Do you have Chemical allergies? ___ yes ____ no

___ Acetone ___ Acetylcholine ___ Auto Exhaust ___ Benzyl Alcohol ___ Chlorine

___ Citric Acid ___Cologne (all) ___ Diesel Exhaust ___ Dopamine ___ Estradiol

___ Ethanol ___ Flourine ___ Formaldehyde ___ Latex ___ Melatonin

___ Newspaper Print ___ Norepinephrine ___ Progesterone ___ Propylene ___ Serotonin

___ Silicone Implant ___ Sponge Rubber ___ Toluene ___ Trichloroethylene

___ Wood Pulp ___ Xylene ___ Other _____

Do you have Drug allergies? ___ yes ___ no

____ Anticonvulsants ___ Codeine ___ Insulin Preparations ___ Iodine ___ Morphine

___ Novocain ___ Penicillin ___ Sulfa ___ Other _____

Do you have Food allergies? ____ yes ____ no

___ Artificial Coloring ___ Artificial Flavorings ___ Beef ___ Coffee/Tea ___ Dairy

___ Eggs ___ Fish/Shellfish ___ Fruits ___ Lamb ___ Nuts ___ Pork ___ Poultry

___ Vegetables ___ Other _____