PATIENT HEALTH HISTORY

Patient Name: _____ **Date:** _____

Instructions: *If you are presently troubled by a particular condition, or if you have ever had a listed condition in the past, please mark the appropriate column below. The information you provide concerning past and present conditions assist your doctor in more thoroughly understanding your state of health. This questionnaire is completely confidential and will not be released without your specific consent.*

Past	Present	
☐	☐	Neck Pain (723.1)
☐	☐	Shoulder Pain (719.41)
☐	☐	Pain in Upper Arm or Elbow (719.42)
☐	☐	Hand Pain (719.44)
☐	☐	Wrist Pain (719.43)
☐	☐	Upper Back Pain (724.1)
☐	☐	Low Back Pain (724.2)
☐	☐	Pain in Upper Leg or Hip (719.45)
☐	☐	Pain in Lower Leg or Knee (729.5)
☐	☐	Pain in Ankle or Foot (719.47)
☐	☐	Jaw Pain (526.9)
☐	☐	Joint ☐ Swelling (719.0) / ☐ Stiffness (719.5)
☐	☐	Fainting (780.2)
☐	☐	Visual Disturbances (728.9)
☐	☐	Convulsions (780.3)
☐	☐	Dizziness (780.4)
☐	☐	Headache (784.0)
☐	☐	Muscular Incoordination (781.3)
☐	☐	Tinnitus (Ear Noises) (388.30)
☐	☐	Rapid Heart Beat (785.0)
☐	☐	Chest Pain (786.50)
☐	☐	Loss of Appetite (783.0)
☐	☐	Irritable Colon (564.1)
☐	☐	Excessive Thirst (783.5)
☐	☐	Chronic Cough (786.2)
☐	☐	Chronic Sinusitis (473.9)
☐	☐	General Fatigue (780.7)
☐	☐	Irregular Menstrual (626.4)
☐	☐	Profuse Menstrual (611.72)
☐	☐	Breast Soreness / Lumps (611.72)
☐	☐	Endometriosis (617.9)
☐	☐	PMS (625.4)
☐	☐	Loss of Bladder Control (788.30)
☐	☐	Painful Urination (788.1)
☐	☐	Frequent Urination (788.41)
☐	☐	Abdominal Pain (789.0)
☐	☐	Constipation / Irregular Bowel Habits (564.0)
☐	☐	Difficulty Swallowing (787.2)
☐	☐	Heartburn / Indigestion (787.1)
☐	☐	Dermatitis / Eczema / Rash (692.9)
☐	☐	Depression (311.9)
☐	☐	Other: _____

Past	Present	
☐	☐	Aortic Aneurysm (441.5)
☐	☐	High Blood Pressure (401.9)
☐	☐	Angina (413.9)
☐	☐	Heart Attack (411.0)
☐	☐	Stroke (436.9)
☐	☐	Asthma (439.9)
☐	☐	Cancer (V10 / 199.1)
☐	☐	Tumor (229.9)
☐	☐	Prostate Problems (601.9)
☐	☐	Blood Disorder (790.6)
☐	☐	Emphysema (492.8)
☐	☐	Arthritis (716.9)
☐	☐	Rheumatoid Arthritis (714.0)
☐	☐	Diabetes ☐ Type I (250.01) ☐ Type II (250.00)
☐	☐	Epilepsy (349.5)
☐	☐	Ulcer (556.9)
☐	☐	Liver Problems (573.9)
☐	☐	Gallbladder Problems (575.9)
☐	☐	Kidney Stones (592.0)
☐	☐	Hepatitis (573.3)
☐	☐	Bladder Infection (595.9)
☐	☐	Kidney Disorders (V11.03)
☐	☐	Colitis (558.9)
☐	☐	Abnormal Weight ☐ Gain (783.1) / ☐ Loss (783.2)
☐	☐	HIV (V08) /AIDS (042)
☐	☐	Anorexia (307.1)
☐	☐	Systemic Lupus (710.0)

Yes	No	
☐	☐	Tobacco ☐ Past (V15.82) ☐ Present (305.1)
☐	☐	Alcohol - If Yes, Frequency: _____
☐	☐	Drug / Alcohol Dependence (V11.3/303.99)
☐	☐	Coffee / Tea / Caffeinated Soft Drinks Servings per Day: _____
☐	☐	Surgeries: _____ _____
☐	☐	Accidents / Injuries: _____ _____
☐	☐	Medications: _____ _____
☐	☐	Allergies: _____ _____

Height: _____ Ft _____ In; **Weight**: _____ lb

Immediate Family Medical History

☐ Cancer (V16)	☐ Chronic Back Problems (V17.89)
☐ Heart Problems (V17.4)	☐ Chronic Headaches (V19.8)
☐ Lung Problems (V17.6)	☐ High Blood Pressure (V17.49)
☐ Diabetes (V18.0)	☐ Rheumatoid Arthritis (V17.7)
☐ Epilepsy (V17.2)	☐ Lupus (V19.8)

☐ Other Condition(s): _____

Yes	No	**For Women**
☐	☐	Are You On Any Form Of Birth Control?
☐	☐	Are You Nursing?
☐	☐	Are You Or Could You Be Pregnant?

If Yes, How Far Along? _____

If No, Last Period? _____