

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_____ Vigorous Exercise	_____ Family Pressures
_____ Moderate Exercise	_____ Financial Pressures
_____ Alcohol Use	_____ Other Mental Stresses
_____ Drug Use	_____ Other (specify)_____
_____ Tobacco Use	_____
_____ Caffeine	_____
_____ High Stress Activity	_____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age []	MOTHER Age []	SPOUSE Age []	BROTHER(S) Age [] Age []		SISTERS Age [] Age []		CHILDREN Age [] Age []	
Arthritis									
Asthma-Hay Fever									
Back Trouble									
Bursitis									
Cancer									
Constipation									
Diabetes									
Disc Problem									
Emphysema									
Epilepsy									
Headaches									
Heart Trouble									
High Blood Pressure									
Insomnia									
Kidney Trouble									
Liver Trouble									
Migraine									
Nervousness									
Neuritis									
Neuralgia									
Pinched Nerve									
Scoliosis									
Sinus Trouble									
Stomach Trouble									
Other:									

If any of the above family members are deceased, please list their age at death and cause:

Patient's Signature _____

PATIENT HISTORY
PERSONAL HISTORY

Patient _____ Date _____
 Childhood Diseases: Measles _____ Mumps _____ Chicken Pox _____ Others _____
 Unusual Childhood Diseases: _____
 Adult Illnesses or Conditions: _____
 Surgeries/Hospitalizations: _____
 Fractures: _____
 Medications: _____
 Are you allergic to any drugs or medications? _____
 Last Physical (date) _____ Findings: _____

Chief Symptoms

Have you ever had the same or similar condition? Yes _____ No _____ If yes, when and describe _____

Have you seen any other doctors for this condition? _____

Is the condition due to injury or sickness arising out of employment? _____

Is the condition due to injury or sickness arising out of an auto or other accident? _____

Days lost from work? _____ Date symptoms appeared or accident happened _____

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please indicate with the letter N if you have these conditions now or P if you have had these conditions previously.

	N = Now		P = Previously
Headaches _____ Frequency _____	_____	Loss of Balance	_____
Neck Pain	_____	Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping Problems	_____	Loss of Taste	_____
Back Pain	_____	Unusual Bowel Patterns	_____
Nervousness	_____	Feet Cold	_____
Tension	_____	Hands Cold	_____
Irritability	_____	Arthritis	_____
Chest Pains/Tightness	_____	Muscle Spasms	_____
Dizziness	_____	Frequent Colds	_____
Shoulder/Neck/Arm Pain	_____	Fever	_____
Numbness in Fingers	_____	Sinus Problems	_____
Numbness in Toes	_____	Diabetes	_____
High Blood Pressure	_____	Indigestion Problems	_____
Difficulty Urinating	_____	Joint Pain/Swelling	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____
Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Women: Are you pregnant? _____			