PATIENT HEALTH FORM

1. What is the main concern that brings you to our office today?

____

2. ALLERGIES TO MEDICATIONS, LATEX, OR ADHESIVE TAPE:

____

3. PRESENT MEDICATIONS:
(List Dosage and Frequency)

______________ ______________
______________ ______________
______________ ______________
______________ ______________
______________ ______________

PAST MEDICAL HISTORY

____
____
____
____
____

4. PREVIOUS SURGERIES (List Dates):

______________ ______________
______________ ______________

5. Musculoskeletal Y N (weakness, pain in joints, swelling in joints, loss of back motion, back problems, TMJ)

6. Are there any other Medical Issues or Problems we need to know about?

____

7. SOCIAL HISTORY:

OCCUPATION:____

HEALTH HABITS: (Circle which substance you use and describe how much)
Caffeine______________________
Tobacco______________________
Alcohol______________________
Other ____

8. HISTORY: (Circle YES or NO if you or any blood relatives had any of the following)

DISEASE			RELATIONSHIP
Arthritis gout	Y	N	
Hepatitis	Y	N	
AIDS/HIV	Y	N	
Cancer	Y	N	
Diabetes	Y	N	
Heart Disease, Stroke	Y	N	
Kidney Disease	Y	N	
Tuberculosis	Y	N	
Heart Failure	Y	N	
Back Problems	Y	N	
Thyroids	Y	N	
Blood Clots	Y	N	

______________________ ______________________ ______________
Please Print Name Patients Signature Date

Dates Chart reviewed MD/Clinical Staff initials: ____ ____ ____ ____ ____ ____ ____ ____
____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____