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Health History

Patient Name:	Birth date:	Date:
Chief Complaint:		

History of Present Injury:

Severity (How severe is the pain/problem on a scale of 0-10?)

Duration (How long have you had this pain/problem?)

Context (Where were you at the onset of this pain/problem?)

Timing (Does the pain/problem occur at a certain time?)

Location (Where is the pain/problem?)

Description (How would you describe the pain/problem?)

Associated signs/symptoms (Other associated problems?)

Modifying factors (What makes the pain/problem better/worse?)

Past Medical History:

Have you ever had the following? Circle N or Y or leave blank if uncertain.

Measles	N	Y	Anemia	N	Y	Epilepsy	N	Y
Mumps	N	Y	High Blood Pressure	N	Y	Back Trouble	N	Y
Chickenpox	N	Y	Low Blood Pressure	N	Y	Arthritis	N	Y
Whooping Cough	N	Y	Migraine Headaches	N	Y	Tuberculosis	N	Y
Scarlet Fever	N	Y	Cancer	N	Y	Last Chest X-ray		
Diphtheria	N	Y	Polio	N	Y	Asthma	N	Y
Smallpox	N	Y	Glaucoma	N	Y	Hives or Eczema	N	Y
Thyroid Disease	N	Y	Hernia	N	Y	Aids or HIV	N	Y
Rheumatic Fever	N	Y	Blood Transfusions	N	Y	Infectious Mono	N	Y
Mitral Valve Prolapse	N	Y	Bleeding Tendency	N	Y	Bronchitis	N	Y
Kidney Disease	N	Y	Diabetes	N	Y	Heart Disease	N	Y
Ulcer	N	Y	Hepatitis	N	Y	Stroke	N	Y
Pneumonia	N	Y	Pregnancy	N	Y	Pacemaker	N	Y

Please list any other problems:

Previous hospitalizations/surgeries/serious illnesses:

Medications (including over-the counter medications)**:**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in my medical status.

Signature of patient, parent or guardian:	**Date:**