HEALTH HISTORY

Name:_____ Date:_____

ALLERGIES: (circle all that apply to you; **write in anything not listed**)
Seasonal Dust Cats/Dogs Sulfa drugs/Sulfonamides Mold Dyes **NONE**
Allergies to medications:_____
Food allergies:_____Other:_____

MEDICAL CONDITIONS: (circle all that apply to you; **write in anything not listed**)

Osteoarthritis	High Cholesterol	Fibromyalgia	**NONE**
Cancer:_____	Stroke	Anxiety/Depression	
Diabetes	Osteopenia/Osteoporosis	Thyroid	
High Blood Pressure	Heart Disease	Asthma	
Rheumatoid arthritis	Kidney Stones	Hepatitis	
HIV/AIDS	Epilepsy	Migraine Headaches	

Other:_____

SURGERIES: (circle all that apply to you; **write in anything not listed**)

Appendectomy	Breast Augmentation	Cervical Spine	**NONE**
Tonsillectomy	Breast Reduction	Thoracic Spine	
Hysterectomy	Brain:_____	Lumbar Spine	
Joint replacement:_____	Rotator Cuff/Labrum R / L	Gall Bladder	
Carpal Tunnel R / L	Kidney Stones	Hernia	
Prostate	Gastrointestinal	Caesarean Section	

Other:_____

SOCIAL HISTORY: (circle all that apply to you)
Cigarettes: <1 pack per day >1 pack per day Quit Second hand smoke **Never**

Exercise: Daily Weekly Never

FAMILY HISTORY: (mark all that apply)

Osteoarthritis	__Parent	__Sibling	**NONE**
Cancer:_____	__Parent	__Sibling	
Diabetes	__Parent	__Sibling	
High Blood Pressure	__Parent	__Sibling	
Rheumatoid arthritis	__Parent	__Sibling	
Heart Disease	__Parent	__Sibling	

List all prescription & over-the counter medications, and nutritional/herbal supplements you are taking:

_____
_____
_____
_____

WOMEN: (circle all that apply to you)
Are you pregnant? __Yes __No __Not sure

Number of pregnancies_____ Number of live births_____

Signature **Date**

_____ ___/___/___ _____

_____ ___/___/___ _____

_____ ___/___/___ _____

_____ ___/___/___ _____

_____ ___/___/___ _____