**Health History Form**

Do you smoke? Y N If yes, packs/day: \_\_\_ Do you drink alcohol? Y N If yes, drinks/week \_\_\_

Name of other physicians who have treated you for this condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been diagnosed with any of the following conditions? (**check all that apply**)

|  |  |  |  |
| --- | --- | --- | --- |
| Heart Disease |  | Asthma |  |
| Pacemaker |  | COPD |  |
| High blood pressure |  | Shortness of breath |  |
| Lower leg swelling |  | Hepatitis |  |
| Dizziness |  | Thyroid Problem |  |
| Arthritis |  | Kidney Disease |  |
| High Blood Pressure |  | Loss of Bladder/Bowel Control |  |
| Circulatory Problems |  | Hernia |  |
| High Cholesterol |  | Osteoporosis |  |
| Stroke |  | Hearing/ visual impairment |  |
| Chest pain/ discomfort |  | Headaches |  |
| Unexplained weight loss |  | Depression |  |
| Cancer: Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Seizures |  |
| Fatique/Energy Loss |  | Contagious Disease |  |
| Diabetes |  | Anemia |  |
| Osteoporosis |  | Vertigo |  |
| Fever/ sweats |  | Hx of falls |  |

Please list any other diagnoses, injuries, or surgeries not listed above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking over-the-counter medication, vitamins or supplements? Y N If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking prescribed medication? Y N If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_