Osteopathic Treatment and Family Medicine Office

Health History Questionnaire-(Adult).Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be absolutely confidential. If you have questions or need clarification about the information requested, please ask us. Thank You.

Name:_____ Date:_____

Age:_____ Sex: F M Birthday:_____Email:_____

Address:_____
(street) (city) (State) (Zip Code)
Cell Phone_____ Home_____ Occupation_____

How Long_____Company Name and Address:_____

In EMERGENCY, notify:_____Phone:_____

Marital Status:_____ Spouse/Partner Name:_____

Spouse/Partner Employer and Address:_____

Family Physician:_____ Phone:_____

Date of Last Visit:_____ Who referred you to this office?_____

Have you received care from an osteopathic physician or received an osteopathic treatment in the past ?__ No __Yes

If yes, details _____

With what main problem would you like us to help you?

Date of symptoms first noticed_____ Have you had this problem in the past?__ Yes __No
Is the condition due to an accident? __Yes __No Is the condition work-related? __Yes __ No

Please be as specific as you can regarding when the problem began and to what extent it interferes with your daily activities (work, sleep, eating, relaxing, hobbies, sex, etc.):

Have you been given a diagnosis for this problem? If so, what?

What kind of treatment, if any, have you tried in the past? Has it helped?

Any recent travel outside of the country?__ No__ Yes Details:_____

Any sick contacts within the past few weeks?__ No__Yes Details:_____

Past Medical History:

__asthma/COPD __seizure history __heart disease/heart attack/CAD __kidney disease __diabetes
__ allergies/hay fever __cancer,type and treatment:_____
__cerebral palsy __pneumonia __rheumatic fever __thyroid disease __ reflux/GERD/peptic ulcer
__hepatitis __tuberculosis __anemia/blood disorder __ high blood pressure/HTN
__stroke/CVA; please describe any residual problems/weakness:_____

previous hospitalization; details:_____

_____

fracture(s) or other significant trauma (auto accidents, falls, head injuries, etc); details:_____

Do you get immunizations? __Yes __No **If so, are your immunization up-to-date?** __ Yes __No

LastTd (tetanus) vaccine _____ Last flu shot_____

Last pneumococcal (pneumonia) vaccine _____ Other (s)_____

Diet History (please describe a typical diet):

Breakfast Lunch Dinner Snack(s)

Are you, or have you ever been on a restricted diet?__No __Yes; please describe_____

Past Surgical History:

__Tonsillectomy __Appendectomy __Hernia repair, location:_____

__ Cholecystectomy (gall bladder removal) __Laparoscopic; for:_____

__other; details:_____

Dental history:

__Extractions __Braces/Head gear __Root canals __Reconstructive surgery __Crowns __Appliances

___other:_____

Current medications (please include vitamins, supplements, herbs, over-the-counter, prescriptions, etc.):

__ I take the following medications on a regular basis-please list specific medication(s):_____

_____

__I take the following medications occasionally-please list specific medication(s):_____

_____

Drug allergies:

__None OR __Specific drug allergies; please list names of medication(s) and reaction, if known:_____

__**Birth History** (if known):_____

Family History (please check the appropriate box to indicate specific illnesses for each family member, if known):

	Living? Yes/No		Age	Allergies	Asthma/ COPD	Cancer, type	Diabetes	Heart disease	High blood pressure	Seizure	Stroke	Other (describe)
Father												
Mother												
Maternal grandmother												
Maternal grandfather												
Paternal grandmother												
Paternal grandfather												
Brother												
Brother												
Sister												
Sister												

Social History:
Living situation:_____

Exercise (type, frequency):_____

Current occupation stressful?__Yes __No Please describe stressors (chemical, physical, psychological, etc.)_____

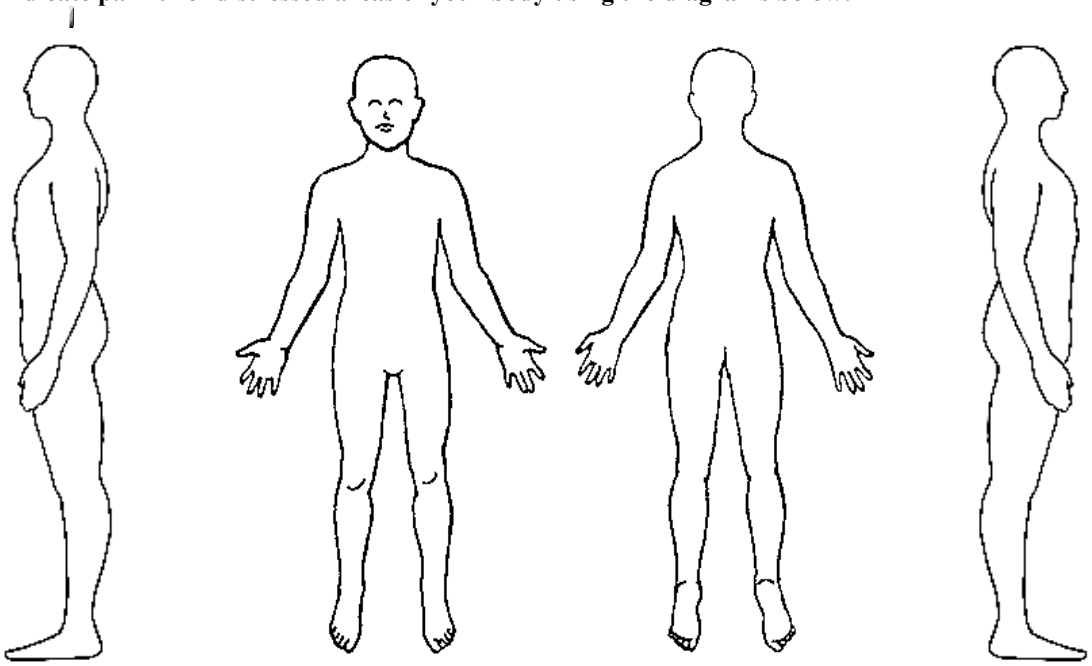
_____

Current or past use of: __Cigarettes/tobacco __Coffee __Tea __Cola __Salt

__Alcohol __Sugar __Drugs __Other:_____

Hobbies/relaxation techniques used:_____

Please indicate painful of distressed areas of your body using the diagrams below:



Systems Review: Have you experienced any of the following within the past few weeks?
General:
__Fever __Chills __Night sweats/sweat easily __Appetite changes __Sleep changes/insomnia __Fatigue
__Weight gain/loss __Cravings __Peculiar tastes or smells __Sudden energy drop (time of the day?)_____

Skin/Hair:
__Rashes __Eczema __Ulceration __Loss of hair __Change in moles/new moles __Change in skin texture
__Itching __ Dandruff __Hives __Acne/pimples __Change in hair texture
__Any other problems?_____

Head, Eyes, Ears, Nose, and Throat:
__Dizziness __Ringing in ears __Changes in hearing __Ear pain __Nose bleeds
__Cataracts __Eye pain/Glaucoma __Glasses __Change in vision __Sore throat
__Eye Strain __Color-blindness __Night blindness __Spots in front of eyes __Jaw click/pain
__Teeth problems __Grinding teeth __Allergies/Sinus problems __Headaches/migraines
__Last optometry exam:_____ Last dental exam:_____
***Please tell us about your headache, including:** location of pain, whether or not it travels/radiates, of stays in the same place; does it come-and-go, or is it constant? What kind of pain is it-sharp, cramping, dull ache, pressure, stabbing. Hot/burning, other? Original injury (if known)? For how long have you been having headaches? What you are doing when the headache start? How long do they last? What make them better/worse?_____

_____

_____

__Other head/eyes/ears/nose/throat problems:_____

Cardlovascular:
__High blood pressure __Low blood pressure __Chest pain __Fainting __Irregular heartbeat
__Blood clots __Dizziness/lightheadedness __Phlebitis __Cold hands/feet __Difficulty breathing
__Swelling of hands __Swelling of feet
__Any other heart or blood vessel problems?_____

Respiratory:
__Cough __Coughing up blood __ Asthma __Bronchitis __Pneumonia __Pain with deep breath
__Difficulty breathing when lying down __Production of phlegm; what color:_____
__Any other lung problems?_____

Gastrointestinal:
__Nausea __Vomiting __Diarrhea __Constipation __Bloating/belching/indigestion
__Black stools __Blood in stools __Rectal pain __Bad breath __Hemorrhoids
__Abdominal pain/cramps __Difficulty swallowing __Vomiting blood
__Any other problems with stomach or intestines?

Genitourinary:
__Pain on urination __Frequent urination __ Blood in urine __Urgency to urinate __Hesitancy
__Unable to hold urine __Kidney stones __Decrease in flow __Sores on genitals __impotence
__Number of night-time awakening to urinate_____ __Any particular color to your urine?_____
__Any other genital or urinary problems?_____

Pregnancy and Gynecologic (female patients only):
__Age at first menses_____ __Date of last menstrual period_____ __Regular/irregular
__Length of menstrual cycle (amount of time between each period)_____days Length of period____days
__Unusual character of bleeding (heavy/light flow/clots) __Painful periods __Painful intercourse
__Vaginal discharge/sore __Change in body/psyche prior to period __breast lumps __Nipple discharge or bleeding
__Number of pregnancies_____ Miscarriages/Abortions_____ Number of births_____
__Last PAP smear (date and results):_____
__History of STD (sexual transmitted disease)? __Yes __No Details _____
__Do you practice birth control?____ If so, what type and for how long?_____
__Any other gynecologic problems?_____

Musculoskeletal:
__Neck pain __Muscle pain __Knee pain __Muscle weakness __Foot/ankle pain
__Hip pain __Shoulder pain __Hand/wrist pain __Join stiffness/pain
__Back pain; where?_____
__Any other joint or bone problems? _____

Neuropsychological:
__Seizure __Dizziness __Areas of numbness __Localized weakness __Loss of balance/poor balance
__Anxiety __Concussion __Poor memory __Lack of coordination __Easily susceptible to stress
__Localized weakness __Poor balance __Tremors
__Depression __Depression with active consideration of suicide OR attempted suicide OR homicide/ __Yes __No
__Have you ever attempted suicide?__No __Yes; when:_____
__Have you ever been treated for emotional problems?_____
__Have you ever lost consciousness? (please describe details) _____
__Any other neurological or psychological problems?_____

Hematologic:
__Easy bruising __Easy bleeding __Prolonged bleeding __Any other hematologic problems?_____

Endocrine:
__Strong thirst __Large volume of urine Hair loss/growth __Weight change __Sleeping changes
__Any other endocrine (thyroid, pituitary, pancreas, adrenals, etc.) problems?_____
_____

_____ _____
Patient's Signature **Date**