

PAST HEALTH HISTORY QUESTIONNAIRE

Please fill out the following answers completely. This information is **VERY IMPORTANT** because it gives us your medical past. Without this information, our health care service to you will be substandard. THANK YOU.

SOCIAL HEALTH HISTORY

WORK HISTORY

How many hours a day do you sit? _____ Stand? _____

How many hours are you at a computer? _____ In a Car? _____

Yes No

_____ Do you have a phone headset?

_____ Do you have an ergonomic chair?

_____ Do you take frequent breaks (i.e. 1/hour)

_____ Do you routinely carry weight over 50 lbs?

_____ How many times a day? _____

_____ **Have you been ergonomically reviewed at your workstation or worksite?**

SLEEP HISTORY

How many hours a night do you sleep? 3-4 5-6 7-8 8+

How old is your current mattress/Bed? _____yrs

What type of mattress is your bed? Spring Foam Water Air

Do you sleep mostly on your: __Side __Stomach __Back

Are you sore in the morning (i.e. neck, lowback, etc)? Y N

Where are you sore? _____

Do you have a cervical (supportive) pillow? Y N Not Sure

Habits

	Yes	No	If Yes, please describe
Smoking	_____	_____	Packs per day: _____
Alcohol Consumption	_____	_____	# of Drinks per day _____ per week: _____
Coffee/Tea Consumption	_____	_____	Cups per day _____
Other Drug Use (street drugs)	_____	_____	Describe: _____
Exercise	_____	_____	___ 2-3X/Wk ___ 4-5X/Wk ___ 6+X/Wk Type: _____

Hobbies/Interests:

Medicines: Please list all currently used medications. Include prescription and non-prescription, herbs, vitamins, supplements.

Allergies: Please list all known allergies, especially medicines: _____

Surgeries: List all previous surgeries: _____

Illness/Infections: List all childhood and adult diseases with year (DO NOT include colds, flu's, etc.): _____

MALES ONLY:

Do You Have:	Yes	No	Yes	No
1. Changes in urine stream	_____	_____	_____	_____
2. Lumps In Testicles	_____	_____	_____	_____
3. Sexual concerns/dysfunction	_____	_____	_____	_____
			4. Prostate Trouble	_____
			5. Incontinence/Urgency	_____

Date of Last Prostate/Testicular Exam: ____ / ____ / ____

PAST MEDICAL HISTORY

PAST HEALTH HISTORY QUESTIONNAIRE

FEMALES ONLY:

Do You Have:	Yes	No	Age Periods Began: _____
1. Menstrual Problems	_____	_____	Number of Pregnancies: _____
2. Abnormal Bleeding	_____	_____	Number of Miscarriages: _____
3. Breast Lump or Pain	_____	_____	Number of Cesarean Sections: _____
4. Problems Getting Pregnant	_____	_____	Type of Birth Control: _____
5. Vaginal Discharge	_____	_____	Date of Last Period: _____
6. Tubal Infections	_____	_____	Date of Last Gynecological Exam: _____
7. Sexual Concerns/Dysfunctions	_____	_____	Are you currently or possible pregnant? Y N

Do You Currently or in the Past Have: Mark all that apply.

	Current	Past		Current	Past
Glaucoma	_____	_____	Asthma	_____	_____
Light Bothers Eyes	_____	_____	Diabetes	_____	_____
Other Eye Problems	_____	_____	Thyroid Troubles	_____	_____
Date of Last Eye Exam ____/____/____			Liver Troubles	_____	_____
Hearing Difficulties	_____	_____	Anemia	_____	_____
Ringing in Ears	_____	_____	Bleeding/Bruising Tendency	_____	_____
Sinus Infections	_____	_____	Low Blood Pressure	_____	_____
Motion Sickness	_____	_____	High Blood Pressure	_____	_____
Dental Problems	_____	_____	Lung/Breathing Difficulties	_____	_____
Date of last Dental Exam ____/____/____			Pneumonia	_____	_____
	Current	Past	Ankle Swelling	_____	_____
Pain or Blood in Urine	_____	_____	Chronic Cough	_____	_____
Leaking Urine	_____	_____	Unexplained Weight Loss	_____	_____
Kidney/Bladder Infection	_____	_____	Bloody/Black Stools	_____	_____
Kidney Stones	_____	_____	Night Sweats	_____	_____
Recurrent Abdominal Pain	_____	_____	Chest Pains/Heaviness	_____	_____
Ulcers	_____	_____	Stroke	_____	_____
Swallowing Problems	_____	_____	Heart Disease/Murmurs	_____	_____
Hernia	_____	_____	Loss of Bowel/Bladder Control	_____	_____
Hemorrhoids	_____	_____	Muscle Weakness (Legs give out)	_____	_____
Loss of Smell	_____	_____	Direct Head Trauma	_____	_____
Arthritis or Gout	_____	_____	Lost Consciousness	_____	_____
Bursitis	_____	_____	Recent Infection	_____	_____
Fractured Bones	_____	_____	History of Osteoporosis	_____	_____
Seizures	_____	_____	History of Cancer	_____	_____
Tremors	_____	_____	Use of corticosteroids (injections, etc)	_____	_____
Passing Out	_____	_____	Use of Anticoagulants	_____	_____
Constipation/Diarrhea	_____	_____	Numbness in Groin	_____	_____
Varicose Veins	_____	_____	Spinal Pain Greater than 4 weeks	_____	_____
			Intravenous Drug Use	_____	_____

FAMILY HEALTH HISTORY (Write the health status and conditions of your family members. If Deceased, from what?)

Mother: _____

Father: _____

Brothers: _____

Sisters: _____

Children: _____

Patient Name: _____ **Signature:** _____ **Date:** _____