



HEALTH HISTORY

Name: _____ Date: _____

List All Current Problems: _____

List Any Other Doctors Seen, Treatments and Results Obtained: _____

Your Current Physician(s) / Therapist(s): _____

List All Surgeries and Their Dates: _____

List Any Medications You Are taking: _____

List Any Traumas And Their Dates: _____

Please Check the Conditions you have or have had:

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Parkinson's Disease | |

Please check all present symptoms:

CARDIOVASCULAR:

- General swelling
- Swelling in legs
- Swelling in face
- Swelling around eyes
- Chest pain
- Pounding heart beat
- Rapid heart beat
- Irregular heart beat
- Blue or purple skin
- Blue or purple nail beds
- Cold hands / feet

VERTERBROBASILAR:

- Double vision
- Loss of coordination
- Loss of memory
- Ringing in ears
- Heart attack
- High blood pressure
- Muscle weakness
- Dizziness
- Blurred vision
- Stroke
- Hypertension

- Inability to form words
- Burning sensations
- Blindness
- Previous head injury
- Previous neck injury
- Taking birth control pills
- Family history of stroke
- Blood vessel disease
- Check if you smoke
- Fainting
- Area of numbness