SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= "O"   SOMETIMES= "S"   NEVER= "N"

___________ Vigorous Exercise

___________ Moderate Exercise

___________ Alcohol Use

___________ Drug Use

___________ Tobacco Use

___________ Caffeine

___________ High Stress Activity

__________ Family Pressures

__________ Financial Pressures

__________ Other Mental Stresses

__________ Other (specify)______

____

____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:
____

__________________________Patient's Signature___________________________________

PATIENT HISTORY

PERSONAL HISTORY

Patient____ Date________________________
Childhood Diseases: Measles__________ Mumps_________ Chicken Pox_________ Others___________
Unusual Childhood Diseases:____
Adult Illnesses or Conditions: ____
Surgeries/Hospitalizations:____
Fractures:____
Medications:____
Are you allergic to any drugs or medications?____
Last Physical (date) ___________________________________ Findings:____________________________

Chief Symptoms

____
____
____
____

Have you ever had the same or similar condition? Yes______ No______ If yes, when and describe ______
____
Have you seen any other doctors for this condition?____
Is the condition due to injury or sickness arising out of employment? ___________________________
Is the condition due to injury or sickness arising out of an auto or other accident? ___________________
Days lost from work?____________ Date symptoms appeared or accident happened __________________

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please indicate with the letter N if you have these conditions now or P if you have had these conditions previously.

N = Now P = Previously

Headaches_________ Frequency ________
Neck Pain ________
Stiff Neck ________
Sleeping Problems ________
Back Pain ________
Nervousness ________
Tension ________
Irritability ________
Chest Pains/Tightness ________
Dizziness ________
Shoulder/Neck/Arm Pain ________
Numbness in Fingers ________
Numbness in Toes ________
High Blood Pressure ________
Difficulty Urinating ________
Weakness in Extremities ________
Breathing Problems ________
Fatigue ________
Lights Bother Eyes ________
Ears Ring ________
Women: Are you pregnant?___________________

Loss of Balance __________
Fainting __________
Loss of Smell __________
Loss of Taste __________
Unusual Bowel Patterns __________
Feet Cold __________
Hands Cold __________
Arthritis __________
Muscle Spasms __________
Frequent Colds __________
Fever __________
Sinus Problems __________
Diabetes __________
Indigestion Problems __________
Joint Pain/Swelling __________
Menstrual Difficulties __________
Weight Loss/Gain __________
Depression __________
Loss of Memory __________
Buzzing in Ears __________