# Health History Form

| Personal Information | | |
|---|---|---|
| **Name:** | | **Date of Birth:** |
| **Height:** | **Weight:** | **Phone #:** |

**Insurance Information**

| Name of Insurance Company | Group Number | Policy Number | Phone Number |
|---|---|---|---|
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**Emergency Contact Information**

| Name of Emergency Contact | Relationship to Patient | Phone Number | Email Address |
|---|---|---|---|
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**Physician Information**

| Name of Physician | Area of Specialty | Office Phone Number | Email Address |
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| Past Medical History | | |
|---|---|---|
| **Surgical Procedure** | **Date of Surgery** | **Name of Surgeon & Hospital** |
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| Please list any additional major injuries or medical events other than surgeries listed above: | |
|---|---|

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| List of Medical Problems: Please circle "Yes" or "No" for each medical problem listed below | | | | | |
|---|---|---|---|---|---|
| **Eyes** | | | **Ears** | | |
| Blurry vision | Yes | No | Decreased hearing | Yes | No |
| Infection/inflammation | Yes | No | Ringing / pain | Yes | No |
| Glasses or contacts | Yes | No | Hearing aid(s) | Yes | No |
| | | | | | |
| **Mouth** | | | **Nose** | | |
| Toothache or gum pain | Yes | No | Nosebleeds | Yes | No |
| Difficulty chewing | Yes | No | Consistent runny nose | Yes | No |
| Dentures | Yes | No | Frequent sinus problems | Yes | No |
| Decreased sense of taste | Yes | No | Decreased sense of smell | Yes | No |
| | | | | | |
| **Throat** | | | **Skin** | | |
| Consistent sore throat | Yes | No | Redness or rash | Yes | No |
| Difficulty or pain when swallowing | Yes | No | Open sores that won't heal | Yes | No |
| Frequent choking | Yes | No | Frequent bruising | Yes | No |
| Persistent cough / phlegm | Yes | No | Changes in hair or nails | Yes | No |
| | | | | | |
| **Heart / Cardiac** | | | **Respiratory** | | |
| High blood pressure | Yes | No | Shortness of breath | Yes | No |
| Chest pain / tightness / pressure | Yes | No | Wheezing / asthma | Yes | No |
| Palpitations | Yes | No | Pain in chest when breathing | Yes | No |
| Vein trouble / pain | Yes | No | Difficulty breathing when lying down | Yes | No |
| Swelling of ankles | Yes | No | Frequent colds or bronchitis | Yes | No |
| Dizziness | Yes | No | Bluish lips / fingers / fingernails | Yes | No |
| | | | | | |
| **Gastrointestinal / Endocrine** | | | **Nervous System** | | |
| Heartburn | Yes | No | Frequent headaches | Yes | No |
| Nausea / vomiting | Yes | No | Seizures or convulsions | Yes | No |
| Abdominal swelling / pain | Yes | No | Poor coordination / balance | Yes | No |
| Constipation | Yes | No | Tremors / twitching | Yes | No |
| Diarrhea | Yes | No | Increased / decreased sensation in hands and feet | Yes | No |
| Diabetes | Yes | No | | | |
| | | | | | |
| **Genitourinary** | | | **Muscle / Skeletal** | | |
| Increased urination or urge to urinate | Yes | No | Stiff or swollen joints | Yes | No |
| Increased bladder infections | Yes | No | Arthritis (osteo or rheumatoid) | Yes | No |
| Pain or burning when urinating | Yes | No | Muscle weakness | Yes | No |
| Unable to control bladder or bowels | Yes | No | Decreased flexibility | Yes | No |
| Change in sex drive | Yes | No | | | |

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