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
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
1. Menstrual Problems	____	____
2. Abnormal Bleeding	____	____
3. Breast Lump or Pain	____	____
4. Problems Getting Pregnant	____	____
5. Vaginal Discharge	____	____
6. Tubal Infections	____	____
7. Sexual Concerns/Dysfunctions	____	____

Age Periods Began: _____
Number of Pregnancies:_____
Number of Miscarriages:_____
Number of Cesarean Sections:_____
Type of Birth Control: _____
Date of Last Period: _____
Date of Last Gynecological Exam:_____
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	____	____
			Anemia	____	____
Hearing Difficulties	____	____	Bleeding/Bruising Tendency	____	____
Ringing in Ears	____	____	Low Blood Pressure	____	____
Sinus Infections	____	____	High Blood Pressure	____	____
Motion Sickness	____	____	Lung/Breathing Difficulties	____	____
Dental Problems	____	____	Pneumonia	____	____
Date of last Dental Exam ____/_____			Ankle Swelling	____	____
	Current	Past		Current	Past
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	____	____
			Lost Consciousness	____	____
Arthritis or Gout	____	____	Recent Infection	____	____
Bursitis	____	____	**History of Osteoporosis**	____	____
Fractured Bones	____	____	**History of Cancer**	____	____
Seizures	____	____	Use of corticosteroids (injections, etc)	____	____
Tremors	____	____	Use of Anticoagulants	____	____
Passing Out	____	____	Numbness in Groin	____	____
Constipation/Diarrhea	____	____	**Spinal Pain Greater than 4 weeks**	____	____
Varicose Veins	____	____	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**:_____