Health History & Assessment

Patient Name______________________________________ **Date**____________

Vitals BP __________ Temp _______ Height _______ Weight _______

Lifestyle history

Exercise: 0 1 2 3 4 5 6 7 days/ wk _______minutes. Type___________________________________

What position do you sleep in: Side Stomach Back Other________________________________

How old is your mattress: _______yrs What type: coil spring foam water air ______________

What type of pillow do you sleep on: foam memory foam fiberfill feather Other________________

Do you wear: arch supports orthotics heel lifts

Do you take; blood thinners (heparin, coumadin, warfarin), birth control pills, steroids

Do you have any family history of; rheumatoid arthritis, gout, ankylosing spondylitis, lupus, stroke

General

Cancer, diabetes, thyroid disease, AIDS or HIV

Fatigue, recent unexplained weight loss, decreased energy, loss of appetite, night sweats, fever or chills, recurrent infections, skin ulcers or rashes, excessive thirst

Neuromusculoskeletal

Stroke, paralysis, seizures, mental disorders, fractures, dislocations, orthopedic problems, arthritis, rheumatoid arthritis, gout, lupus, osteoporosis, scoliosis

Change in vision, smell, hearing or taste, light headedness, dizziness/ vertigo, loss of consciousness, difficulty speaking or swallowing, headaches, numbness or tingling, difficulty walking, change in mood or behavior

Cardiovascular

Pacemaker, defibrillator, high blood pressure, heart disease, irregular heart beat, heart attack, congestive heart failure, TIA, peripheral vascular disease, blood clotting or bleeding disorder, anemia

Chest pain, shortness of breath, nose bleeds, swollen ankles, redness or swelling of a limb, unusual bruising, bleeding gums, swollen lymph nodes

Respiratory

Asthma, emphysema, tuberculosis, COPD

Cough or change in cough, blood in sputum, wheezing, difficulty breathing

Digestive

Liver disease, hepatitis, ulcers, gall stones, appendicitis, pancreatitis, reflux disease

Stomach pain, pain or difficulty swallowing, indigestion, nausea, vomiting, diarrhea, constipation, bloating, excessive gas or belching, blood in stool, black stools, jaundice

Genitourinary

Kidney disease, kidney stones, prostate enlargement

Burning with urination, blood in urine, increased frequency of urination, difficulty with urination, loss of bladder or bowel control, change in menstrual bleeding

Completed by ___________________________

Family medical history (please list any pertinent diseases affecting your family and cause of death if applicable)

Father:____

Mother:____

Siblings:____

____

Grandparents:____

Other:____

Do you have any family history of rheumatologic problems; rheumatoid arthritis, lupus, gout, ankylosing spondylitis ____

Personal medication history

Please list any prescription or over the counter medication you are currently taking (__ see attached list)

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Do you take; blood thinners (heparin, coumadin, warfarin), birth control pills, steroids

Please list any known medication allergies____

Surgical history

Please list any prior surgeries & hospitalizations (starting with the most recent)

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Social history

Marital status: M S W D

Occupation____

Do you smoke No Yes How much____

Do you drink alcohol No Yes How much on a typical day__________________________________