

PERSONAL HEALTH HISTORY FORM (Back Pain)

Name:		Date:	
DOB:	Age:	Male / Female	Right / Left Handed
<i>If patient is a minor, name of adult with him/her today:</i>			<i>Relationship:</i>
Current/Last Occupation:	Employer/School:	Highest/Current Education Level :	
Job physical activity requirements:		<i>If Disabled, list reason:</i>	
Current/Recent Sports or Physical Activity:			
Primary Care Physician:		Referring Physician:	

REASON FOR TODAY'S VISIT

*Please answer **all** of the following questions.*

How long has it hurt?		Exactly where does it hurt?	
Does the pain travel/radiate? Y / N	If so, where?		
Did anything happen that started the pain?			
			When?
Scale of 0-10, 10 being the worst pain Imaginable:	Right Now:	At its best:	At its worst:
Is it constant or sporadic?		Describe:	
What kind of pain is it? (e.g. sharp, dull, aching, electrical, throbbing, etc.)			
Is there pain at night? Y / N	Does it wake you up? Y / N	Any numbness or tingling? Y / N (if so where):	
What makes the pain better?			
What makes the pain worse?			
Please circle if you have had any of the following changes since the onset of your back pain: fevers chills unexpected weight loss loss of control of leg muscles numbness or tingling in your groin or between your legs loss of control of your bowel or bladder			
What treatments (e.g. meds, therapy, surgery) have you already tried?			
Have you seen any physician(s) (other than the referring physician) previously for this problem or a problem in the same region? (Please list): When/ Where?			
Do we have records from these physicians? Y / N (If no, please fill out a release of information form so that we can obtain records)			
Have you had any tests because of this problem such as blood work, x-rays, MRI, etc.? What were the results?			

CURRENT AND PAST MEDICAL CONDITIONS

Please list all of your current and past medical conditions, as well as surgeries and hospitalizations. If none, write "N/A".

1.	5.
2.	6.
3.	7.
4.	8.

Have you ever experienced any of the following during or shortly after exercise: chest pain, unexpected shortness of breath, fainting, or near-fainting? If so, please list and explain below. If none, write "N/A".

REPRODUCTIVE HISTORY (FEMALES ONLY)

Are you pregnant? Y / N	Date of last period:	Date of last Pap smear:
How many periods have you had in the last 12 months?		Date of last mammogram:

Name: _____

DOB: _____

Date: _____

MEDICATIONS

Please list all medicines which you currently or have recently used, both prescription and non-prescription/over the counter medications, including herbal medications and vitamins/supplements. Please include the dose and how frequently you take them. If none, write "N/A".

1.	5.
2.	6.
3.	7.
4.	8.

MEDICINE ALLERGIES

Please list any medicines to which you are allergic and what happens if you take them. If none, write "N/A".

1.	4.
2.	5.
3.	6.

HEALTH RELATED HABITS

Do you use tobacco? Y / N	What kind?	How long?	How much daily?	Have you tried to quit? Y / N
Do you drink alcohol? Y / N	What kind?			
How much do you drink each week?	Have you had any problems with alcohol? Y / N			
Have you ever used any illicit drugs? Y / N If yes, IV/Injection, Cocaine, Marijuana, Anabolic Steroids	What kind?		How often?	
Do you exercise routinely? Y / N	What kind?		How often?	
Do you follow a special diet? Y / N	What kind?			
When was your last tetanus vaccination?				

IMMEDIATE FAMILY HEALTH HISTORY

Relative	Age (or deceased)	Health Problems (or cause of death)
Father		
Mother		
Brother/Sister		
Brother/Sister		

REVIEW OF SYSTEMS

In the past few months, have you had any of the following symptoms? If yes, please explain below.

	Y	N		Y	N		Y	N
Sudden vision changes			Frequent cough			Easy bruising or bleeding		
Sudden hearing changes			Coughing up blood			Change in appetite		
Nose, sinus, mouth, or throat problems			Fevers or severe chills			Weight loss or gain		
Dizziness			Night sweats			Extreme fatigue or weakness		
Fainting or loss of consciousness			Chest pain			Change in sleeping pattern		
Convulsions or seizures			Heart beat changes			Difficulty tolerating stress		
Frequent or severe headaches			Swelling of hands or feet			Depression		
Swollen lymph glands			Heat or cold intolerance			Problems involving work		
Skin disease or rash			Change in urine patterns			Significant joint pains, stiffness, or swelling (circle)		
Other skin changes			Change in bowel movements			Other:		
Shortness of breath			Abdominal pain or bloating			Other:		

ADDITIONAL NOTES

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