

PATIENT HEALTH HISTORY (page 2)

7. If you have ever had a listed symptom in the *past*, please check the *past* column. If you are *presently* experiencing a particular symptom, check the *present* column.

<i>Symptom</i>	<i>Past</i>	<i>Present</i>	<i>Symptom</i>	<i>Past</i>	<i>Present</i>
Neck pain			Jaw Pain		
Shoulder Pain			Fainting		
Pain in upper arm/elbow			Seizures		
Hand pain			Dizziness		
Upper back pain			Headache		
Low back pain			Rapid heart beat		
Pain in upper leg or hip			Chest pains		
Pain in lower leg or knee			Abnormal weight [] gain [] loss		
Pain in ankle or foot			Dermatitis or Eczema		
Numbness/tingling/weakness in arm/leg (circle one)			Balance/Coordination Problems (stumbling, tripping, dropping items)		
Stiffness in joint Specify joint:			Swelling in joint Specify joint:		
Difficulty speaking or swallowing			other:		

2. If you have ever had a listed condition in the *past*, please check the *past* column. If you are *presently* experiencing a particular condition check the *present* column.

<i>Condition</i>	<i>Past</i>	<i>Present</i>	<i>Condition</i>	<i>Past</i>	<i>Present</i>	<i>Condition</i>	<i>Past</i>	<i>Present</i>
High blood pressure			Arthritis			Coronary Artery Bypass Graft		
Angina			Diabetes			Chronic Obstructive Pulmonary Disease		
Heart Attack			Ulcer			Pneumonia		
Stroke			Kidney/bladder problems/incontinence			Peripheral Arterial Disease		
Asthma			Depression			Acquired Respiratory Distress Syndrome		
Emphysema			Osteoporosis			Taking blood pressure medication		
Congenitive heart failure			Valvular Disease			Chronic Bronchitis		
Atherosclerotic Disease			Stents			Allergies		
Angioplasty			Arrhythmia			Neurological Disease Parkinson's, MS, etc.		
Gastrointestinal Disease ulcer, hernia, reflux, etc			Visual Impairment: glaucoma, macular degeneration, etc			Anxiety or panic disorders		
Sleep Dysfunction			Prosthesis/implants			Cancer		

Infectious/communicable disease (HIV, AIDS, Hepatitis, etc.) _____

Previous accidents: _____

Hearing impairment; very hard of hearing, even with hearing aids [] yes [] no

Any other condition not specified above? _____

3. List any surgeries you have had beginning with the most recent: _____

4. Are you currently pregnant? [] Yes [] No

5. If you take medication, please list them: _____

Medication allergies? [] Yes [] No If yes, please list: _____

6. How would you rate your general stress level? [] none [] minimal [] moderate [] high

7. Activity level at work: [] sit more than 50% of time [] light manual labor [] moderate manual labor [] heavy manual labor

8. Describe your general activities both work and recreational: Present: _____

Desired: _____

9. Do you: [] smoke # of packs per day: _____ [] Drink alcohol # of drinks per week: _____

10. Do you have permanent Disability status? [] yes [] no If so, location: _____ date rating received: _____ rating percentage: _____

11. Is your present problem affecting your ability to work or otherwise be active? [] no effect [] some physical restrictions [] need limited assistance

[] need assistance often [] significant inability without assistance [] I am totally disabled and cannot care for myself

Specific activities that you cannot perform since your problem began: _____

12. Home environment: Do you live alone? [] yes [] no Does someone assist you with activities? [] yes [] no if yes, who? _____

Do you live in a [] 1 story or [] 2 story home? Must you use stairs to enter/exit your home? [] yes [] no

Patient Signature: _____ Date: _____

Patient's representative: _____ Relationship to patient: _____ Rev. 9-08