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**

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 have a cervical (supportive) pillow? Y N Not Sure

Do you sleep mostly on your: __Side __Stomach

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: Bike Swim Run Weights Group Fitness Crossfit Personal Trainer Tennis Yoga/Pilates Other:__________

Hobbies/Interests:

PAST MEDICAL HISTORY

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:____

____

Past Injuries: ____

____

PAST HEALTH HISTORY QUESTIONNAIRE

MALES ONLY:

Do You Have:	Yes	No		Yes	No
1. Changes in urine stream	____	____	4. Prostate Trouble	____	____
2. Lumps In Testicles	____	____	5. Incontinence/Urgency	____	____

FEMALES ONLY:

Do You Have:	Yes	No	
1. Menstrual Problems	____	____	Age Periods Began: _________________
2. Abnormal Bleeding	____	____	Number of Pregnancies:______________
3. Breast Lump or Pain	____	____	Number of Miscarriages:______________
4. Problems Getting Pregnant	____	____	Number of Cesarean Sections:__________
5. Vaginal Discharge	____	____	Type of Birth Control: _______________
6. Tubal Infections	____	____	Date of Last Period: _________________
			Date of Last Gynecological

Do You Currently or in the Past Have: Mark all that apply.

EYES	Current	Past	**ENDOCRINE**	Current	Past
Glaucoma	____	____	Thyroid Disease	____	____
Light Bothers Eyes	____	____	Diabetes	____	____
Other Eye Problems	____	____	Type 1____ Type 2____		
Date of Last Eye Exam ____/_______			**Osteoporosis**	____	____
EARS, NOSE, THROAT			Other Endocrine Disease	____	____
Hearing Difficulties	____	____	**CARDIOVASCULAR**		
Ringing in Ears	____	____	Low/High Blood Pressure	____	____
Sinus Infections	____	____	Shortness of Breath/Fainting	____	____
Motion Sickness	____	____	Heart Pacing Problems	____	____
Dental Problems	____	____	Heart Disease/Murmurs	____	____
Loss of Smell	____	____	Ankle Swelling	____	____
Lung/Breathing Difficulties	____	____	Conduction Block/Fibrillation	____	____
Swallowing Difficulties	____	____	**GENERAL**		
GENITOURINAL			Anemia	____	____
Pain or Blood in Urine	____	____	Recent Infection	____	____
Leaking Urine	____	____	Unexplained Weight Loss	____	____
Kidney/Bladder Infection	____	____	Night Sweats, Fever or Chills	____	____
Kidney Stones	____	____	**History of Cancer**	____	____
Hernia	____	____	Fatigue	____	____
ABDOMINAL			**NEUROLOGICAL**		
Hemorrhoids	____	____	Double Vision	____	____
Bloody/Black Stools			Lost Consciousness/Head Trauma		

PAST HEALTH HISTORY QUESTIONNAIRE

FAMILY HEALTH HISTORY (Write the health status and conditions of your family members. If Deceased, from what?)

Parents:____

Siblings:____

Patient Name:_______________________ **Signature**:________________________ **Date**:______