Health History

Name: _____ Date: _____

List All Current Health Problems: _____

_____

_____

List Any Other Doctors Seen, Treatments And Results Obtained: _____

_____

_____

Your Current Physician(s)/Therapist(s): _____

_____

List All Surgeries And Their Dates: _____

_____

_____

List Any Medications You Are Taking: _____

_____

_____

List Any Traumas And Their Dates: _____

_____

_____

Please Check The Conditions You Have Or Have Had:

( ) AIDS
( ) Anemia
( ) Arthritis
( ) Cancer
( ) Chronic fatigue
( ) Depression
( ) Diabetes
( ) Epilepsy
( ) Fibromyalgia
( ) Hypoglycemia
( ) Multiple sclerosis
( ) Parkinson's disease
( ) Polio
( ) Rheumatic fever
( ) Rheumatoid arthritis
( ) Tuberculosis
( ) Venereal disease

Please Check All Present Symptoms::

CARDIOVASCULAR

( ) General swelling
( ) Swelling in legs
( ) Swelling in face
( ) Swelling around eyes
( ) Chest pain
( ) Pounding heart beat
( ) Rapid heart beat
( ) Irregular heart beat
( ) Blue or purple skin
( ) Blue or purple nail beds
( ) Cold hand/feet

VERTEBROBASILAR

( ) Double vision
( ) Loss of coordination
( ) Loss of memory
( ) Rringing in ears
( ) Heart attack
( ) High blood pressure
( ) Muscle weakness
( ) Dizziness
( ) Blurred vision
( ) Stroke
( ) Hypertension
( ) Inability to form words
( ) Burning sensations
( ) Blindness
( ) Previous head injury
( ) Previous neck injury
( ) Taking birth control pills
( ) Family history of stroke
( ) Blood vessel disease
( ) Check if you smoke
( ) Fainting
( ) Area of numbness