STILLPOINT

An Osteopathic Health Center
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HEALTH HISTORY
(CONFIDENTIAL)

Name____Today's Date________________

Age_______Birthdate________Sex_____Marital status: married single divorced separated other

What is the reason for your visit?____

SYMPTOMS - Check (√) symptoms you currently have or have had regularly in the past:

General
Chills
Depression
Dizziness
lightheadedness
unsteadiness
spinning-vertigo
Fainting
Fatigue
Fever
Forgetfulness
Headache
Loss of energy
Loss of sleep
Motion sickness
Nervousness
Numbness
Sweating
Weight loss

Eyes
Blurred vision
Crossed/lazy eye(s)
Double vision
Farsightedness
Loss of vision
Nearsightedness
Visual flashes
Visual halos
Wear glasses/lenses

Ear, Nose, Throat
Bleeding gums
Earache
Ear discharge
Ear fullness
Ear infections
Hay fever
Hoarseness
Jaw clicking
Jaw locking
Loss of hearing
Noises in ears
left right
high pitched
low roar
pulsating
Nosebleeds
Post-nasal drip
Sinus problems
Sore throat
Swallowing difficulty

Cardiovascular
Chest pain
Chest pressure
High blood pressure
Irregular heart beat
Low blood pressure
Poor circulation
Rapid heart beat
Swelling of ankles
Varicose veins

Respiratory
Coughing up blood
Shortness of breath
Persistent cough
with sputum
green
yellow
white
clear
bloody
Nightsweats
Wheezing

Gastrointestinal
Abdominal pain
Anal itching
Bloating
Constipation
Diarrhea
Black stools
Blood in stools
Hemorrhoids
Mucous in stools
Nausea
Vomiting

Skin
Bruise easily
Hives
Itching
Change in moles
Rash
Scars
Sore that won't heal

Muscle/Joint/Bone
Pain in:
Neck Shoulder
Arms Hands
Back Hips
Legs Feet
Jaw joints
Joint swelling
Limb numbness
Limb weakness

Genitourinary
Frequent urination
Bladder control
Painful urination
Painful intercourse
Pelvic pain
Sexual dysfunction
Urinary hesitancy

Women only
Age menses began___

Date of last menstrual period_____________

Periods are :
Regular Irregular
Painful
Heavy Scant
Duration:
Days in between____
Days of flow_______

Pregnancies
Total Number _______

Term pregnancy_____
Premature_____
Abortions_____
Living children_____

CONDITIONS Check (√) conditions you have or have had in the past:

AIDS	Bulimia	Hernia	Multiple sclerosis	Suicide attempt
Alcoholism	Cataracts	Herpes	Mumps	Thyroid problems
Anemia	Chemical dependent	Hiatal hernia	Pacemaker	Tonsillitis
Anorexia	Coma	High cholesterol	Pneumonia	Tuberculosis
Appendicitis	Diabetes	HIV positive	Polio	Typhoid fever
Arthritis	Emphysema	Joint replacement	Prostate problem	Ulcers
Asthma	Epilepsy	Kidney disease	Post-partum Blues	Unconsciousness
Bleeding disorders	Glaucoma	Liver disease	Psychiatric care	Vaginal infections
Blood in urine	Gonorrhea	Measles	Rheumatic fever	Venereal disease
Breast lump	Gout	Migraine headaches	Rheumatoid arthritis	
Bronchitis	Heart disease	Miscarriage	Scarlet fever	
Cancer	Hepatitis	Mononucleosis	Stroke	

Name____Date__________________________

HOSPITALIZATIONS AND SURGERIES		
Year	*Hospital*	*Reason for hospitalization and outcome*

CHILDBIRTH HISTORY		
Year of birth	*Sex*	*Complications, if any*

SERIOUS INJURIES, FRACTURES OR OTHER ILLNESSES		
Event or illness	**Date**	**Outcome**

DENTAL HISTORY	
Extractions no yes teeth numbers	Do you currently or did you have:
Bridges no yes (upper lower)	overbite underbite crooked teeth buck teeth
Does any bridge cross the midline? no yes	Orthodontia no yes, age
Root canals no yes	Reason for orthodontia:
Dentures upper lower partial Age last fit	Temporomandibular Joint (TMJ):
Implants no yes	splints no yes (upper lower)
	surgery no yes (left right)
	disc implants no yes (material=)

Medications (include dosage amount and frequency)	ALLERGIES: to medications or substances
Pharmacy **Name**________________________**Phone**_____________	

Name____Date__________________________

FAMILY HISTORY **Fill in health information about your family**				
Relation	*Age*	*State of health*	*Age at death*	*Cause of death*
Father				
Mother				
Brothers				
Sisters				

Please (√) If your blood relatives have had:		
	Disease	*Relationship*
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	
	Other	

HEALTH HABITS Check (√) which substances you use and describe how much you use		
	Caffeine	
	Tobacco	
	Drugs	
	Water	
	Alcohol	
	Chocolate	
	Sugar	
	Other	

OCCUPATIONAL CONCERNS Check (√) if your work exposes you to the following:	
	Stress
	Hazardous Substances
	Heavy Lifting
	Other

EXERCISE	
Type	Frequency

Your Occupation____

Have you ever had a blood transfusion? No Yes (please give approximate dates__________________)

x______________________________________ ____________________

Patient and/or guardian signature Date