

PATIENT HISTORY

Marital Status: Single Married Widowed Separated / Divorced

Gender: Male Female

Race: White Black Asian Hispanic Other

Personal Health History:

Condition	Never	Past	Present
1 Eye Problems			
2 Wear Glasses or Contacts			
3 Ear Problems			
4 Difficulty Hearing			
5 Nose, Throat, Sinus Problems			
6 Breathing Problems			
7 Tuberculosis			
8 Asthma / Lung Disease			
9 Bronchitis			
10 Chest Pain			
11 Palpitations (Heart Racing)			
12 High Blood Pressure			
13 Heart Problems			
14 High Cholesterol			
15 Swollen Ankles or Feet			
16 Diabetes			
17 Kidney Problems			
18 Stroke or Paralysis			
19 Epilepsy (Seizures)			
20 Black Out Spells or Fainting			
21 Recurrent Headaches			
22 Head Injury or Loss of Consciousness			

Condition	Never	Past	Present
23 Urinary Problems			
24 Stomach / Bowel Problems			
25 Skin Rash / Disease			
26 Hernia or Rupture			
27 Cancer or Tumor			
28 Back Pain			
29 Mental Illness			
30 Muscle Weakness			
31 Change in Weight over 10 lbs			
32 Allergies to Food (List)			
33 Allergies to Medication (List)			
34 Broken Bones or Fractures			
Where and Date			
Where and Date			
35 Joint Pain			
Type			
Type			
36 Operations (List and Date)			
#1			
#2			

Have you ever had a serious injury, accident, or any other medical condition not listed above? Please specify type and include dates:

Current Medical Care: Are you currently under a physician's care?

Physician	For What Medical Condition	Last Seen (Date)

Current Medication Usage: Do you take any medications regularly or as needed? Include over-the-counter medications.

Medication Name	For What Medical Condition	Date Started



Patient History

Employee Identification

Name (Last, First, MI): _____

Date of Birth: _____

Company / Employer: _____

Date of Service: _____

Family Health History: Have any members of your family (mother, father, sister, brother, grandparents) had health problems?

Relation	Age	Medical Condition (Heart, Lung, Cancer, etc.)	Status

Personal Habits: Please complete the following table regarding your personal habits.

Do You ...?	Frequency					Age Start	Age Stop
	Never	Occ.	Daily	Weekly	Monthly		
Smoke (Cigarettes/Cigar/Pipe) <small>circle</small> (# _____ per day)							
Use Tobacco (Chewing/Snuff)							
Exercise (Type):							
Participate in Hobbies (Type):							
Use Caffeine Drinks (Coffee/Tea/Colas)							
Drink Alcohol (Type):							
Play Sports (Type):							

Work Health History: Please indicate Yes or No, Date, and Description.

Question	Yes	No	Which & Type of Job	When (Dates)
Have you ever worked in a dusty trade such as mining, quarry, foundry work, sandblasting, or a chemical industry?				
Have you ever worked with asbestos?				
Have you ever worked with or been treated with x-ray, radioactive material or laser?				
Have you ever had any serious ill effects from the kind of work you have done?				
Have you ever filed for Workers' Compensation due to an injury or accident?				

I certify that the above answers are true and complete and will be relied upon by Health Care Personnel for an accurate exam.

X _____

Date _____



Patient History

Employee Identification

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