Outpatient Health History

NAME:		TODAY'S DATE:
DATE OF BIRTH:	GENDER: ☐ M ☐ F	☐ Right handed ☐ Left handed

MEDICAL/SURGICAL HISTORY

Please check if you have ever had:

☐ Arthritis	☐ Lung/Breathing Problems	☐ Allergies
☐ Broken bones	☐ Diabetes/High Blood Sugar	☐ Thyroid Problems
☐ Osteoporosis	☐ Stroke	☐ Cancer
☐ Blood Disorder	☐ Head Injury	☐ Infectious Diseases (TB, Hepatitis)
☐ Circulation Problems	☐ Multiple Sclerosis	☐ Kidney Problems
☐ Heart Problems	☐ Parkinson's Disease	☐ Drug Resistance Infections
☐ High Blood Pressure	☐ Seizures/Epilepsy	☐ Ulcers/Stomach Problems
☐ Depression/Anxiety	☐ Skin Disorders	☐ Other:

Please check if you have experienced the following symptoms in the past year:

☐ Chest pain	☐ Loss of balance or falls	☐ Bowel problems
☐ Heart palpitations	☐ Difficulty in walking	☐ Weight loss/gain
☐ Cough	☐ Joint pain or swelling	☐ Urinary problems
☐ Hoarseness	☐ Pain at night	☐ Fever/chills/sweats
☐ Shortness of breath	☐ Difficulty sleeping	☐ Headaches
☐ Dizziness or blackouts	☐ Loss of appetite	☐ Hearing problems
☐ Coordination problems	☐ Nausea/Vomiting	☐ Vision problems
☐ Weakness in arms or legs	☐ Difficulty swallowing	☐ Other:

Have you ever had surgery? ☐ **yes** ☐ **no** **If yes, please describe and provide date**

	Date:
	Date:
	Date:

MEDICATIONS

Do you take any prescription medications? ☐ **yes** ☐ **no** **If yes, please list below:**

Do you take any non-prescription medications? ☐ **yes** ☐ **no** **If yes, please check all that apply:**

☐ Aleve/Naproxen	☐ Tylenol/Acetaminophen	☐ Antacids
☐ Advil/Ibuprofen	☐ Antihistamines	☐ Herbal Supplements
☐ Aspirin	☐ Decongestants	☐ Other:

DIAGNOTIC TESTS

Please indicate if you have had any of the following tests within the past year?

☐ X-rays	☐ Bone Scan	☐ EKG (electrocardiogram)	☐ Echocardiogram
☐ CT Scan	☐ Arthroscopy	☐ Angiogram	☐ Pulmonary Function Test
☐ MRI	☐ EMG (electromyogram)	☐ Stress Test	☐ Bronchoscopy
☐ Myelogram	☐ NCV (nerve conduction velocity)	☐ Ultrasound	☐ Other:

SOCIAL HISTORY

Where do you live?	☐ Private Home	☐ Apartment	☐ Rented Room
	☐ Assisted Living	☐ Group Home	☐ Other:
Does your home have:	☐ Stairs, no rail	☐ Stairs, rails	☐ Ramp
	☐ Elevator	☐ Uneven terrain	☐ Assistive Equipment (i.e. bath)
Do you use:	☐ Cane	☐ Walker	☐ Crutches
	☐ Manual WC	☐ Motorized WC	☐ Leg Braces
Do you:	☐ Smoke ____ ppd	☐ Drink alcohol, ___/week	☐ Exercise, ___x/week for ___ mins.

Rate your General Health Status: ☐ excellent ☐ good ☐ fair ☐ poor

____

Signature of person providing this information