Past Health History

Name_____ **Date**_____

Please mark what applies, each symptom, or condition that you have had: (Prior to this Injury)

General Symptoms
__Dizziness
__Fainting
__Headache
__Nervous
__Numbness
__No sleep
__Depression
__Neuralgia
Other_____
_____
_____

Respiratory Symptoms
__Asthma
__Chronic Cough
__Difficulty Breathing
__Spitting Blood/
__Phlegm
Other_____
_____
_____

Gastro-Intestinal
__Gas
__Diarrhea
__Constipation
__Liver/ Gallbladder
__Nausea
__Vomiting
__Colitis
Other_____
_____
_____

Male/Female
__Breast Lumps
__Painful Urination
__Miscarriage
__Prostate
__Sexual Dys.
Other_____
_____
_____

Exercise
__None
__Light
__Moderate
__Active
__Very Active

Cardio-Vascular
__High Blood Pressure
__Low Blood Pressure
__Pain over Heart
__Rapid/Slow Heart
__Heart Attack
__Stroke
__Poor Circulation
__Swelling Ankles
Other_____
_____
_____

Musculo-skeletal
(prior to injury)

__Neck Pain
__Mid Back Pain
__Low Back Pain
__Shoulder Pain
__Elbow Pain
__Wrist/Hand Pain
__Hip Pain
__Knee Pain
__Ankle/Foot Pain
_____
_____
_____
Other_____
_____
_____

Skin
__Eczema
__Hives
__Itching
__Rash
__Dermatitis
Other_____
_____
_____

EENT
__Eyes
__Ears
__Nose
__Throat
__Allergies
Other_____
_____
_____

Diseases
__Diabetes
__Cancer
__Anemia
__Heart
__Arthritis

Family History
__Diabetes
__Cancer
__Stroke
__Heart Disease
__Kidney
Other_____
_____
_____
_____
_____

Habits
__Smoking
__Drinking
__Caffeine
Other_____
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Notes
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***All starred notations indicate that a recommendation to a PCP/MD has been made.**

Reviewed by: Dr._____ Signature:_____