Personal Health History

Are you pregnant or considering getting pregnant? _____
Number of pregnancies _____ Number of live births _____

Do you wear a pacemaker? _____ Do you have a history of seizures? _____

For each system listed below please describe current concerns first, followed by past concerns. Be sure to include any accidents, illnesses, or chronic problems. Write on the back if you need more space. (examples are in paraentheses).

Skeletal/Bones (broken bones, arthritis, osteoporosis, scoliosis, back pain): _____

_____

Muscular, Connective tissue, Muscles, Joints (cramps, twitching, sprains, bursitis, disc problems: _____

Eyes, Ears, Nose and Throat, Mouth & Jaw (TMJD, braces, hearing, vision, speech, sinus, sore throats): _____

_____

Respiratory/Lungs (asthma, bronchitis, frequent colds, pneumonia, shortness of breath):

_____

Circulatory/Heart, arteries, veins (hypertension, varicose veins, bleed or bruise easily, swollen ankles): _____

_____

Nervous System / Brain, Nerves (headaches, memory problems, concussion, stroke, seizures, ringing in ears, shooting pains, tingling or numbness): _____

_____

Endocrine Pituitary, hypothalamus, reproductive, thyroid (menstrual, fertility, PMS, diabetes, growth problems):

_____

Digestive and Elimination stomach, intestines, bladder (constipation, loose stools, irritable bowel, urinary tract infections, frequent night urination):

_____

_____

Skin (rashes, psoriasis, eczema, warts): _____

Mental and Emotional (depression, anxiety, lack of focus, nervousness, poor memory):

_____

_____