BELLINGHAM OSTEOPATHIC CENTER, PC
Health History

Today's Date: _____

Please complete the entire Health History Form and write "N/A" in any section that does not apply.

Patient's Name: _____ Date of Birth: _____

Have you traveled outside of the country in the last 6 months? ___yes, ___ no.

If yes please specify what country _____.

MEDICATIONS: Please list all medications you are currently taking, please include Vitamins, Aspirin, Tylenol, etc.

Name of Medication and dosage amt: Reason for taking: Prescriber:

_____
_____
_____
_____
_____
_____

*****Allergies to medications*****

_____
_____

Other allergies:

Date of last Pneumonia vaccine_____ Date of last Influenza vaccine_____

NEUROLOGICAL HISTORY: Please check if you have had any of these and give the date of onset, frequency, and details.

____ Fainting spells _____
____ Dizziness _____
____ Equilibrium/Balance _____
____ Motion sickness _____
____ Tinnitus (ear ringing) _____
____ Vision problems _____
____ Memory problems _____
____ Attention/Concentration problems _____
____ Weakness in extremities _____
____ Burning in extremities _____
____ Numbness in extremities _____
____ Cramps in extremities _____
____ Differences between body sides _____
____ Other _____

DIAGNOSTIC TESTING AND/OR IMAGING: (X-ray, CAT scan, MRI, Etc.) Please give the doctor's name and where the test was preformed, approximate date and results of the testing if known:

_____
_____
_____
_____

SURGERIES: Please list all surgeries with the approximate date:

_____
_____
_____
_____
_____

HEADACHES:

Age at onset: _____ Frequency: _____
Pattern: _____
Duration: _____
Any diagnosis or treatment: _____
_____

ILLNESSES: Please circle any that you have had in the past or currently have:

Measles	Rheumatic Fever	Croup	Rubella	Infectious Mononucleosis	Sinusitis
Chicken Pox	Ear Infection	Meningitis	Mumps	Urinary Tract Infection	Tonsillitis/Strep Throat
Whooping Cough	Pneumonia	Staph Infection	Scarlet Fever	Bronchitis	Yeast Infection

Other:_____
_____

OTHER HEALTH CONDITIONS: Please check if you have had of these and give the approximate date of onset and frequency of incident or list as "ongoing."

____ Anemia _____
____ Hypoglycemia _____
____ Low blood pressure _____
____ Thyroid problems _____
____ Kidney problems _____
____ Cancer _____
____ Obesity/Overweight _____
____ Back problems _____
____ Scoliosis _____
____ Constipation _____
____ Hiatus hernia _____
____ Bladder problems _____
____ Foot problem _____

____ Diabetes _____
____ High blood pressure _____
____ Heart problems _____
____ Gallbladder problems _____
____ Asthma _____
____ Other respiratory problems _____
____ Under weight _____
____ Neck problems _____
____ Ulcer/Stomach problems _____
____ Irritable bowel _____
____ Other digestive problems _____
____ Rheumatoid arthritis _____
____ Hepatitis __A __B _____

Other or additional details:

_____
_____

GYNECOLOGICAL HISTORY: Please circle any of the following you have had.

PMS	Menstrual Cramps	Heavy Bleeding	Infertility	Miscarriages	Hot Flashes

Other:_____

PREGNANCIES:

How many: _____ Complications: _____

SMOKING:
Do you smoke: ____ No, never ____ Quit, how long ago: _____
____Yes How often/how many: _____ For how long: _____

SPECIAL DIETS: (Dairy free, low fat, vegetarian, regular, diabetic, gluten free, ketogenic, high fiber, kosher, low carb, low calorie, low fat, vegan, vegetarian.)
_____
_____
_____

EXERCISING: What exercising do you do? How often? How long at a time? Please include competitive sports
_____
_____
_____
Aerobic flexibility: ___, light ___, moderate ___, heavy ___,
Duration 30 min ___, 60 min ___, 1 hr. or more ___.

SLEEP:
Hours per night: ____.

DENTAL:
Brushing teeth: daily ___, twice daily ___, irregular ___.
Cleanings by dentist: quarterly ___, semi- annual ___, annual ___.
Any type of dental appliances: dentures ___, braces ___, TMJ appliance ___, snoring appliance ___.

VISION:
Readers ___, prescription glasses ___, contacts ___.
Eye exam in the last two years? ___ yes, ___no.

HEARING:
Hearing aid? ___yes, ___no.
Hearing test in the last two years? ___yes, ___no.

Flexibility
FRACTURES: Please list all fractures and their after effects, if any:
_____
_____
_____

HEAD INJURIES: Please list all head injuries with cause, treatment, after effects, and approximate date:
_____
_____
_____

OTHER MAJOR INJURIES: Please list all other major injuries:
_____
_____
_____

OTHER DOCTORS: Please list all doctors, therapists, etc. that you are currently seeing.

_____
_____
_____

FAMILY HISTORY: Please circle yes or no depending on the health of your family member, if N is circled please describe the issues, conditions and or illnesses related to that particular family member.

Mother: Healthy (Yes) or (No) No, please explain:_____
Deceased Cause: _____

Father: Healthy (Yes) or (No) No, please explain:_____
Deceased Cause: _____

Siblings: #_____ Healthy (Yes) or (No) No, please explain:_____
Deceased Cause: _____

# of brothers _____, #of sisters_____.

Significant others: _____, # of children_____, ages_____.

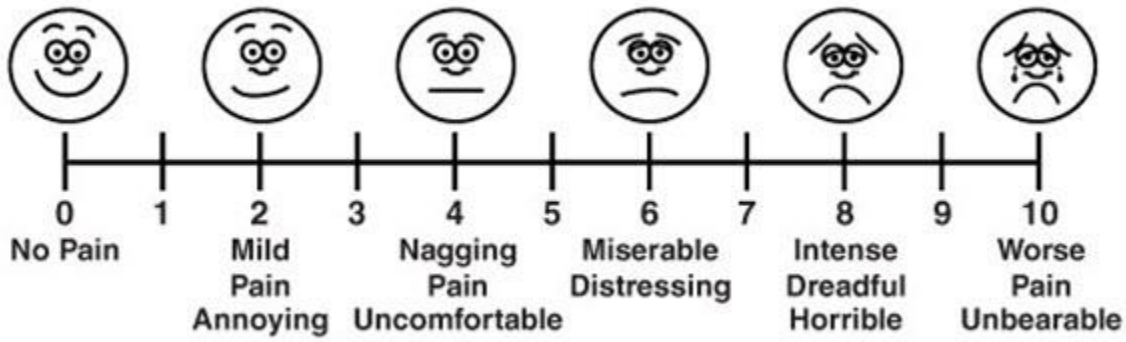
Is there any history of these following conditions in your family other than yourself?
If yes, please list the family member(s) next to the corresponding condition.

Cancer: _____ Diabetes: _____
Hypoglycemia: _____ High blood pressure: _____
Heart problems: _____ Low blood pressure: _____

(Continued)

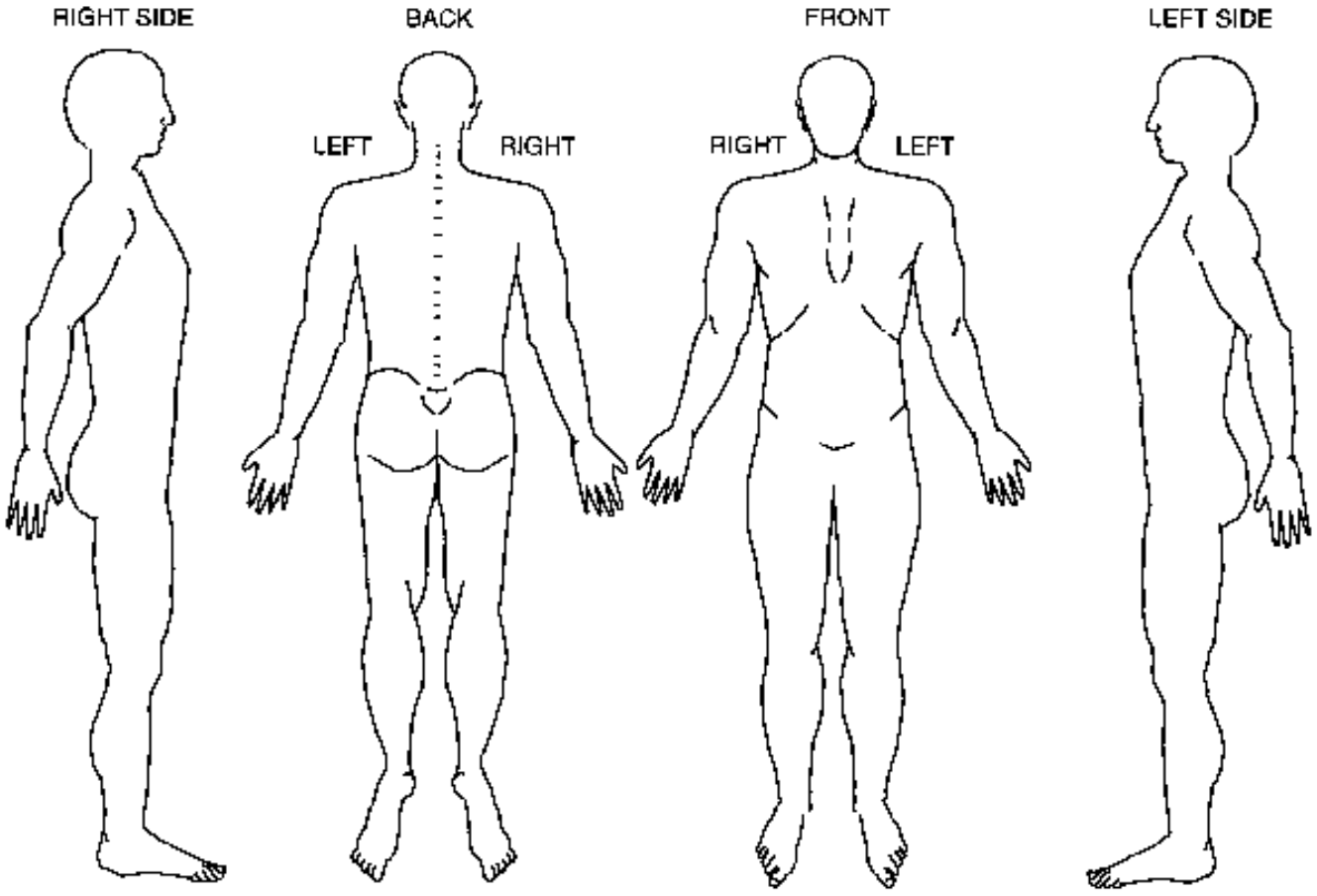
Asthma: _____ Other respiratory problems: _____
Allergies: _____ Kidney problems: _____
Gallbladder problems: _____ Weight problems: _____
Headaches: _____ Structural problems (back, neck, etc.) _____
Other: _____
Alcohol use occasional, _____, regular_____, social_____, heavy.

PAIN SCALE: Please mark an X on the graph below to show your average pain.



PAIN LOCATION: Please draw the location and type of pain on the body outlined below, using these below:

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STANDING	OTHER
////////	BBBBBBBB	XXXXXXXX	- - - - - - - - - - - -	SSSSSSSSS	OOOOOOO
////////	BBBBBBBB	XXXXXXXX	- - - - - - - - - - - -	SSSSSSSSS	OOOOOOO



PAIN QUESTIONAIRE:

Is it possible that the pain or injury is related to a specific incident? YES or NO

If yes, please provide the details and date of the incident:

_____

_____

How long have you had this pain? _____

Does your pain move into or radiate to another part of your body, if so, what location? _____

What makes the pain worse? _____

What makes the pain better? _____

Did your pain start suddenly or come on slowly? _____

Have you had any numbness or tingling in your limbs, if so where? _____

What treatments have you tried for your pain? _____

Is your pain worse with certain movements? _____

How has your pain changed since it started? _____

Does your pain effect your daily activities? _____

Does your pain interfere with sleep? _____

Is the pain present all the time or does it come and go? _____

Have you had this pain before, or is this the first time? _____

Have you had any swelling, if so where? _____

Do you have any muscle weakness or the feeling of inability to move? _____

Have you had a fever? _____

Have you had a change in weight? _____

Have you noticed a rash? _____

Have you had any blurred or double vision? _____

Has this pain caused any chest pain at all? _____

Are you nauseated with the pain? _____

What type of work do you do? _____

Does your job require you to sit or stand for long periods of time? _____

Have you recently started a new sport, done any vigorous exercise, or heavy manual labor? _____

Have you been under more stress than usual? _____

Has your pain affected your personal care (washing, dressing, etc.)? _____