Patient Health History

Patient Name:____Date:_________________________________

1. **What is your status? (Circle answer and if not employed, skip to question 4)**
   a. Employed (If so, what is your occupation? ____)
   b. Unemployed c. Student d. Retired e. Homemaker f. Disabled

2. **If employed, are you (circle)**
   a. Working your normal job without restrictions
   b. Working in your normal job with restriction (Please Explain)_____________________________________
   c. Working in an alternate job
   d. Currently not working due to your present injury/impairments

3. **What are your primary job tasks? (Circle all that apply)**
   a. Prolonged sitting
   b. Prolonged standing
   c. Lifting
   d. Repetitive tasks (like computer, writing, phone work, assembly)
   e. Operating a machine
   f. Driving
   g. Other____

4. **Please circle any of the following health conditions that you now have or had in the past. (Circle)**
   a. None
   b. Cancer
   c. Diabetes
   d. High Blood Pressure
   e. Heart problems
   f. Rheumatoid arthritis
   g. Osteoarthritis
   h. Asthma
   i. Emphysema
   j. Overweight
   k. Unexplained weight loss
   l. Seizures
   m. Chemical dependency
   n. Smoker
   o. Currently Pregnant
   p. # of pregnancies______
   q. Mental Illness
   r. Thyroid disease
   s. Multiple Sclerosis
   t. Hepatitis
   u. Tuberculosis
   v. Kidney disease
   w. Anemia
   x. Stroke
   y. Osteoporosis
   z. History of fractures
   aa. Menopausal
   bb. Incontinence
   cc. Depression
   dd. Other______________________

5. **Please circle any medications that you are taking (over the counter and prescription). (Circle)**
   a. None
   b. Anti-Inflammatory
   c. Pain Medications
   d. Muscle relaxants
   e. Steroids
   f. Anti-depressants
   g. High Blood Pressure Medications
   h. Heart Medications
   i. Hormone replacement therapy
   j. Anti-seizure medications
   k. Thyroid Hormone
   l. Heparin/Coumadin
   m. Meds to increase bone density
   n. Other_____________________________

   ***Please list any allergies you have**:____

6. **Please list any surgeries you have had and the date performed:**_________________________________
   ____
   ____