

Optimal Health Chiropractic
6420 W. Spring Mtn. Rd.
Las Vegas, NV 702-838-1200

Health History Form

Patient Name _____ DOB _____

Age _____ Date of Last Physical Exam _____ M.D. _____

What is your reason for visiting our office? _____

Symptoms

Check symptoms you currently have or have had in the past year

GENERAL

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of Weight
- Nervousness
- Numbness
- Sweats

GASTROINTESTINAL

- Appetite poor
- Bloating
- Heartburn
- Constipation
- Diarrhea
- Excessive Thirst
- Excessive Hunger
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach Pain
- Vomiting
- Vomiting blood

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful Urination
- Urinary tract infection

WOMEN ONLY

- Abnormal pap smear
- Bleeding between periods
- Irregular periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Other

CARDIOVASCULAR

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

EYE, EAR, NOSE, THROAT

- Blurred vision
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Vision-flashes
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision-Halos

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

MEN ONLY

- Prostate pain/problems
- Problems with ejaculation
- Testicular pain

- Arms
- Back
- Feet
- Hands
- Hips
- Legs
- Neck
- Shoulders

Conditions

Check conditions you currently have or have had in the past

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Prostate problem |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio | |

Family History

Check (✓), if your blood relatives had the following

Disease	Relationship
<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Gout	_____
<input type="checkbox"/> Asthma, Hay fever	_____
<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Heart disease	_____
<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> High blood pressure	_____
<input type="checkbox"/> Kidney disease	_____
<input type="checkbox"/> Tuberculosis	_____

Hospitalizations/Surgeries

Year	Hospital	Reason for hospitalization
_____	_____	_____
_____	_____	_____
_____	_____	_____

Accidents/illnesses/injuries

Date _____	Outcome _____
Date _____	Outcome _____
Date _____	Outcome _____

Your health is affected by your nervous system, but it is also affected by your environment, food, and lifestyle activities and habits. **Please answer the following:**

			Comments:
Do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Is your diet healthy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Do you exercise?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Do you sleep well at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Is your job stressful?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

Occupational

Check if your work exposes you to the following:

Stress Heavy lifting Repetitive movements Hazardous substances

Occupation _____

As a child:

Do you know if your birth was a difficult one? Yes No Do not know

Did you have any accidents, falls, traumas, or injuries? Yes No

If yes, please explain: _____

Did you participate in any sports activities? Yes No

If yes, please explain: _____

Please indicate **any medications** you are currently taking:

Blood pressure Steroids Antibiotics Insulin
Muscle relaxant Pain killers Birth control pills Other

Name of medications: _____

Name of nutritional supplements _____

Pregnancies

Birth yr.	Complications (if any)
_____	_____
_____	_____
_____	_____

Are you currently pregnant? Yes No

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____