

# Patient Health History

---

Today's Date  /  Signature of Patient \_\_\_\_\_

Patient Title: (check one)  Mr.  Mrs.  Ms.  Miss  Dr.  Prof.  Rev.

First Name \_\_\_\_\_ Nick Name \_\_\_\_\_

Last Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Suffix \_\_\_\_\_

Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Primary Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_

Home email \_\_\_\_\_ Work Email \_\_\_\_\_

*By providing my email address, I authorize my doctor to contact me via the email address(es) provided.*

Which email address would you like us to use to communicate with you? (check one)  Home  Work

Contact Method (check one)

Primary Phone  Secondary Phone  Mobile Phone  Home Email  Work Email

Date of Birth  /  Age \_\_\_\_\_ Gender (check one)  Male  Female  Unspecified

Marital Status (check one)  Single  Married  Other SSN \_\_\_\_\_

Employment Status (check one)

Employed  FT Student  PT Student  Other  Retired  Self Employed

Race (check one)

White  Black/African American  Hispanic  American Indian/Alaskan Native  
 Asian  Asian Indian  Chinese  Filipino  
 Japanese  Korean  Vietnamese  Native Hawaiian or other Pacific Island  
 Samoan  Guamanian or Chamorro  Other \_\_\_\_\_  I choose not to specify

Multi-Racial (check one)  Yes  No  Unknown

Ethnicity (check one)  Hispanic or Latino  Not Hispanic or Latino  I choose not to specify

Preferred Language (check one)

English  Spanish  American Sign Language  Chinese  French  German  
 Tagalog  Vietnamese  Italian  Korean  Russian  Polish  
 Arabic  Portuguese  Japanese  French Creole  Greek  Hindi  
 Persian  Urdu  Gujarati  Armenian  I choose not to specify

Continued ...

**Verification Question** (choose only one question by circling the question, then give the answer to that question)

- What is the name of your favorite pet?    In what city were you born?    What high school did you attend?  
 What is your favorite movie?    What is your mother's maiden name?    On what street did you grow up?  
 What was the make of your first car?    When is your anniversary?

**Verification Answer to the Chosen question:** \_\_\_\_\_

*Answers must be at least 6 characters.*

**Do you currently smoke tobacco of any kind?**    Yes    Former smoker    Never been a smoker

**If yes, how often do you smoke:**    Current every day smoker    Current sometimes smoker

**If yes, what is your level of interest in quitting smoking?**

- 0    1    2    3    4    5    6    7    8    9    10  
*No interest* *Very Interested*

**Current medications, including frequency and dosage if known. If there are no current medications, check here:**

	Start Date		Start Date
1) _____		5) _____	
2) _____		6) _____	
3) _____		7) _____	
4) _____		8) _____	

**List any known allergies you have had to any medications.**

**If no allergies are known, check here:**

- 1) \_\_\_\_\_ 3) \_\_\_\_\_  
2) \_\_\_\_\_ 4) \_\_\_\_\_

**Briefly list your main health problems:** \_\_\_\_\_  
\_\_\_\_\_

**Has any doctor diagnosed you with Hypertension presently?**    Yes    No   **If yes, describe:** \_\_\_\_\_  
\_\_\_\_\_

**Has any doctor diagnosed you with Diabetes presently?**    Yes    No   **If yes, what kind?**    Type I    Type II  
**If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?**    Yes    No    Not Sure  
**If yes, other comments regarding Diabetes:** \_\_\_\_\_

**Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days?**    Yes    No

**To be performed by clinic staff:**

**Height:** \_\_\_\_\_ inches   **Weight:** \_\_\_\_\_ pounds   **BP:** \_\_\_\_\_ / \_\_\_\_\_