HEALTH HISTORY FORM

Date: _____

Allergies (include medication allergies): _____

Latex Allergy/Sensitivity: ☐ Yes ☐ No Adhesive Allergy/Sensitivity: ☐ Yes ☐ No

Healthcare Professionals from whom you are Currently Receiving Treatment:

☐ Medical Doctor (MD) ☐ Psychiatrist/Psychologist ☐ Chiropractor

☐ Osteopathic Doctor (DO) ☐ Physical Therapist (PT) ☐ Other:

Have you EVER been diagnosed with any of the following conditions (check all that apply):

Condition	Yes	No	Condition	Yes	No
Anemia	☐	☐	Hypertension	☐	☐
Arthritis - Rheumatoid/Osteoarthritis/Psoriatic	☐	☐	ICD/Pacemaker/Defibrillator	☐	☐
Asthma	☐	☐	MRSA, VRE, C.Diff, Antibiotic Resistant Organism	☐	☐
Cancer (type): (date):	☐	☐	Multiple Sclerosis	☐	☐
Chemical Dependency	☐	☐	Osteoporosis/Osteopenia	☐	☐
COVID-19 (diagnosis date):	☐	☐	Scoliosis	☐	☐
Depression	☐	☐	Seizures	☐	☐
Diabetes Mellitus	☐	☐	Shingles	☐	☐
Emphysema	☐	☐	Smoker (in the past or present)	☐	☐
Headaches/Migraines	☐	☐	Stroke	☐	☐
Heart Disease	☐	☐	Thyroid Disease	☐	☐
Hepatitis	☐	☐	Tuberculosis	☐	☐
HIV/AIDS	☐	☐	Other (indicate):	☐	☐

For Women: Are you currently pregnant or think you might be pregnant? ☐ Yes ☐ No

Surgeries or Other Significant Conditions for which you have been treated (including fracture, dislocations, sprains). Include approximate date of injury.

Injury	Date	Injury	Date

Prescription or Over-the-Counter Medications and Herbal Supplements which you have taken in the last week. Include dose and frequency.

Medication	Dose	Frequency	Medication	Dose	Frequency

Have you recently noticed any of the following? (check yes or no for each)

Condition	Yes	No	Condition	Yes	No
Bowel Dysfunction	☐	☐	Night Pain	☐	☐
Fatigue	☐	☐	Unexpected Weight Gain/Loss	☐	☐
Fever/Chills/Sweats	☐	☐	Urinary Frequency Changes	☐	☐
Nausea/Vomiting	☐	☐			

At the present time would you say your health is (choose one): ☐ Excellent ☐ Very Good ☐ Fair ☐ Poor

Have you had any falls in the past year? ☐ Yes ☐ No If yes, how many?
When?

Emergency Contact Name: _____

Phone #: _____

My signature verifies that the information provided is correct to the best of my knowledge.

_____ _____
Patient or Designated Decision Maker (signature) Date Time

_____
If Designated Decision Maker (print name) Relationship