



## Health History

### FAMILY:

Have your biological parents, siblings or children had any of the following?

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Cancer – type: _____               | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Stroke                             | <input type="checkbox"/> Arthritis    |
| <input type="checkbox"/> Neurological Conditions (ex. M.S.) |                                       |

### PAST TRAUMAS:

- Have you had any car accidents?    Y   N    When? \_\_\_\_\_
- Have you had any broken bones?    Y   N    When? \_\_\_\_\_    Which? \_\_\_\_\_
- Have you had any concussions?    Y   N    When? \_\_\_\_\_
- Have you had any dislocations?    Y   N    When? \_\_\_\_\_    Where? \_\_\_\_\_

### SIGNIFICANT PAST ILLNESS:

Please list any other significant illnesses you have had as an adult or child.

Illness	Years old	Comments
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

### PAST SURGERIES:

Please list in chronological order any surgeries you have had.

Type	Year/Age	Comments
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

### PREVIOUS TESTS:

Have you had any of the following tests?

	Year	Comments
<input type="checkbox"/> Spinal X-rays	_____	_____
<input type="checkbox"/> CT Scans	_____	_____
<input type="checkbox"/> MRIs	_____	_____
<input type="checkbox"/> Nerve Tests (EMG)	_____	_____
<input type="checkbox"/> Bone Density	_____	_____