

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 _____

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

Contact Method (check all that apply)

Primary Phone Secondary Phone Mobile Phone Home Email Work Email Text Message

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

Place of Employment: _____

Insured's Name (if not self) _____ Insured's DOB /

Insured's Place of employment _____ Insured's SSN _____

Family Physician _____ Referred by: _____

Race (check one)

- | | | | |
|-----------------------------------|---|--------------------------------------|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Black/African American | <input type="checkbox"/> Hispanic | <input type="checkbox"/> American Indian/Alaskan Native |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Chinese | <input type="checkbox"/> Filipino |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Korean | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Native Hawaiian or other Pacific Island |
| <input type="checkbox"/> Samoan | <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> Other _____ | <input type="checkbox"/> 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)

- | | | | | | |
|----------------------------------|-------------------------------------|---|--|--|---------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Spanish | <input type="checkbox"/> American Sign Language | <input type="checkbox"/> Chinese | <input type="checkbox"/> French | <input type="checkbox"/> German |
| <input type="checkbox"/> Tagalog | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Italian | <input type="checkbox"/> Korean | <input type="checkbox"/> Russian | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Japanese | <input type="checkbox"/> French Creole | <input type="checkbox"/> Greek | <input type="checkbox"/> Hindi |
| <input type="checkbox"/> Persian | <input type="checkbox"/> Urdu | <input type="checkbox"/> Gujarati | <input type="checkbox"/> Armenian | <input type="checkbox"/> I choose not to specify | |

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? What is your favorite color?

Verification Answer to the Chosen question: _____

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 dosage if known. (If you have an existing list we are able to make a copy)
If there are no current medications, check here:

- 1) _____ 7) _____
- 2) _____ 8) _____
- 3) _____ 9) _____
- 4) _____ 10) _____
- 5) _____ 11) _____
- 6) _____ 12) _____

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:** _____ / _____ **HR:** _____