

David Gilboe and Assoc., Inc

PATIENT HISTORY

Instructions: Please complete as much as possible. All information will be kept confidential.

Patient Name: _____ Height: _____ Weight: _____

A. CURRENT MEDICATIONS (name only):

See attached list

B. Health History

1. ILLNESS/MEDICAL PROBLEM:

Please put an X by any of the following conditions you have/had and give an approximate year that they started.

Add any additional comments or explanations in space provided.

ILLNESS	X	Year	Comments/Explanations
High blood pressure	<input type="checkbox"/>	_____	_____
Heart attack	<input type="checkbox"/>	_____	_____
Chest pain	<input type="checkbox"/>	_____	_____
Congestive heart failure	<input type="checkbox"/>	_____	_____
Blood clot	<input type="checkbox"/>	_____	_____
Irregular heart beat	<input type="checkbox"/>	_____	_____
Mitral valve prolapse	<input type="checkbox"/>	_____	_____
Other heart conditions	<input type="checkbox"/>	_____	_____
Emphysema	<input type="checkbox"/>	_____	_____
Asthma	<input type="checkbox"/>	_____	_____
Shortness of breath	<input type="checkbox"/>	_____	_____
HIV	<input type="checkbox"/>	_____	_____
Cancer or tumor	<input type="checkbox"/>	_____	_____
Stomach/GI condition	<input type="checkbox"/>	_____	_____
Liver trouble	<input type="checkbox"/>	_____	_____
Hepatitis	<input type="checkbox"/>	_____	_____
Hernia	<input type="checkbox"/>	_____	_____
Kidney or bladder disease	<input type="checkbox"/>	_____	_____
Prostate problem	<input type="checkbox"/>	_____	_____
Headaches	<input type="checkbox"/>	_____	_____
Dizziness	<input type="checkbox"/>	_____	_____
Seizures	<input type="checkbox"/>	_____	_____
Thyroid disease	<input type="checkbox"/>	_____	_____
Head injury	<input type="checkbox"/>	_____	_____
Stroke	<input type="checkbox"/>	_____	_____
Arthritis	<input type="checkbox"/>	_____	_____

- Bleeding tendency _____
- Diabetes _____
- Skin conditions _____
- Mental illness/depression _____
- Broken bones _____
- Joint sprains _____
- Eye/vision problems _____
- Hearing loss _____
- Allergies _____
- Other _____

2. SURGERIES: Gall bladder Tonsils Appendix Hysterectomy Hernia
 C-Section Coronary bypass Thyroidectomy
 Neck Surgery Back Surgery Carpal Tunnel Cataract
 List surgeries: _____

3. Special Tests: (relating to your current complaint)
 X rays EMG Doppler MRI arthrogram CAT scan bone scan
 Other _____

C. SOCIAL/PERSONAL HISTORY

Currently live: Alone With parents With siblings With spouse With friends
 With children Ages? _____ With significant other

Type of dwelling House one-story two-story three story
 Apartment 1st floor 2nd floor other _____

How many stairs does it take to enter your home? _____

Have you experienced any falls within the past six months? No Yes

If yes, describe circumstance: _____

Do you have relatives/ friends who can help you with your care? No Yes

Do you have relatives/ friends who are dependent on you for care? No Yes

Do you exercise regularly? No Yes How often? _____

Type of exercise: _____

Were you involved in sports prior to your current complaint? No Yes

Type of Sport: _____

Has your current complaint limited your participation in exercise or sports? No Yes

Do you have any hobbies? No Yes Describe: _____

Are you currently employed outside of the home? No Yes

If yes, describe the activities you have to perform to complete your job:

Signature of person filling out form: _____ Date: _____