



Department of Osteopathic Manipulative Medicine  
4190 City Avenue, Suite 330  
Philadelphia, Pennsylvania  
215-871-6425

### Health History

(Please circle answers that apply)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Allergies to medications? \_\_\_\_\_  No Allergies

#### Family History:

Father Alive? Yes No Current age or age of death \_\_\_\_\_

Mother Alive? Yes No Current age or age of death \_\_\_\_\_

Parents', brothers' or sisters' Medical Problems

(Please place initial next to item = F, M, B, S)

Arthritis \_\_\_\_\_ Cancer \_\_\_\_\_ Heart Attack/Disease \_\_\_\_\_

Stroke \_\_\_\_\_ Diabetes \_\_\_\_\_ Osteoporosis \_\_\_\_\_

Any other significant family medical problems? \_\_\_\_\_

#### Social History:

Occupation: \_\_\_\_\_

Do you smoke? Yes No If yes, then how much? \_\_\_\_\_

Drink Alcohol? Yes No How much? Rarely Occasionally Weekends Daily

Caffeine type/amount? \_\_\_\_\_

Exercise (what kind and how often)? \_\_\_\_\_

Special diet? \_\_\_\_\_

Hobbies? \_\_\_\_\_

Religious/Spiritual Affiliation? (optional): \_\_\_\_\_

#### Medical History: (please circle all that apply)

Arthritis Anxiety Back problem Cancer Carpal tunnel syndrome

Cervical degenerative disc disease Depression Diabetes Gout Hypertension

Lumbar disc disease Kidney stone Migraine Heart disease Intestinal

problem Osteoarthritis Osteoporosis Rheumatoid arthritis Sciatica

Short leg Stomach ulcer Stroke Spinal stenosis Thyroid disease

Other medical problems? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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**Trauma History** : Please describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred): \_\_\_\_\_  
\_\_\_\_\_

**Surgical History:**  
Please list all major surgeries: \_\_\_\_\_  
\_\_\_\_\_

**Medications:**  
Please list all medications you are taking: \_\_\_\_\_  No Medications  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all supplements you are taking: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Symptoms/Information (Please circle all that apply to you AT THIS TIME)**

- |                     |                      |                    |
|---------------------|----------------------|--------------------|
| Fatigue             | Wheezing             | Extremity weakness |
| Fever               | Chest pain           | Rash               |
| Night Sweats        | Palpitations         | Back pain          |
| Ear pain            | Abdominal pain       | Joint swelling     |
| Eye pain            | Loss of appetite     | Neck pain          |
| Sore throat         | Urinary incontinence | Easy bleeding      |
| Cough               | Cold intolerance     | Seasonal allergies |
| Shortness of breath | Extremity numbness   |                    |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_