PHILADELPHIA · COLLEGE · OF · OSTEOPATHIC · MEDICINE

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 | Fever | Night Sweats |
| Headache | Eye discharge | Visual loss |
| Hearing loss | Nasal drainage | Chest pain |
| Palpitations | Cough | Problems breathing |
| Wheezing | Abdominal pain | Decreased appetite |
| Vomiting | Urinary incontinence | Numbness/tingling |
| Itching | Rash | Back pain |
| Neck stiffness | Cold intolerance | Easy bleeding |
| Hay fever | | |

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_____