



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: _____

Reason for visit? _____

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? _____

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: _____



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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_____