

# Confidential Health History

This will be part of your confidential health record. Indicate any health problems you have had. Provide details or approximate date if relevant.

Name \_\_\_\_\_ Date \_\_\_\_\_

## 1. Have you had any of the following:

- Motor vehicle accidents  
year \_\_\_\_\_ year \_\_\_\_\_ year \_\_\_\_\_
- Injuries, Falls or Traumas  
type \_\_\_\_\_ year \_\_\_\_\_  
type \_\_\_\_\_ year \_\_\_\_\_  
type \_\_\_\_\_ year \_\_\_\_\_
- Surgeries  
type \_\_\_\_\_ year \_\_\_\_\_  
type \_\_\_\_\_ year \_\_\_\_\_  
type \_\_\_\_\_ year \_\_\_\_\_

2. Are you taking any medications? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 3. Please indicate what helps you relieve any pain:

- heat or cold                       lying down
- medication                         rest
- sitting                                 standing
- walking                                other \_\_\_\_\_

## 4. General Health Issues

- alcoholism                           anemia
- bleeding                               cancer
- chills                                  depression
- diabetes                               dizziness
- drug abuse                          fainting
- fatigue                                 fevers
- headaches                          nervousness
- night sweats                        phobias
- seizures                               thyroid disease
- weight gain or loss                other \_\_\_\_\_

## 5. Gastrointestinal

- allergies                             asthma
- belching/gas                       bloody stools
- breathing problems               chronic cough

# Elisabetta Alfonsi MS DC DACNB

## 5. Gastrointestinal (continued)

- constipation                         diarrhea
- difficulty swallowing            heartburn
- hemorrhoids                         hernia
- liver problems                     nausea
- pain in abdomen                  pneumonia
- other

## 6. Respiratory

- shortness of breath               spitting phlegm/blood
- vomiting                             vomiting blood
- other

## 7. Cardiovascular

- heart pain                           high blood pressure
- irregular heartbeat              prior heart problem
- stroke                                swelling
- other

## 8. Musculoskeletal

- arthritis                             numbness/tingling
- pain                                  spinal curve
- stiffness                           swelling
- tremors                             twitching
- weakness                          other

8a. Any sports injuries? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 9. Skin

- hair changes                       itching
- moles                                 nail changes
- rash                                  redness
- scars                                 other

## 10. Ears, Eyes, Nose & Throat

- dental problems                  double vision
- ears ringing                        eye pain
- hearing problems                nosebleeds
- poor vision                         sinus problems
- throat problems                  other

### 10a. Do you wear contacts or glasses?

- contacts                             glasses

10b. Date of last eye exam: \_\_\_\_\_

