GENERAL HEALTH HISTORY

DaySpring Family Wellness Center

Patient Name _____ Mark the conditions that apply to you.

Past	Present		Past	Present	
☐	☐	Neck Pain	☐	☐	Urinary Problems
☐	☐	Headaches/Migraines	☐	☐	Easy Bruising
☐	☐	Arm-Hand Pain/Numbness/Tingling	☐	☐	Tobacco Use
☐	☐	Pain Between Shoulders	☐	☐	Shortness of Breath
☐	☐	Low Back Pain	☐	☐	Allergies/Asthma
☐	☐	Leg/Foot Numbness/Tingling	☐	☐	Dental Problems
☐	☐	Medication Side Effects	☐	☐	Fibromyalgia
☐	☐	Diabetes	☐	☐	Blood Thinner Use
☐	☐	Hands or Feet Cold	☐	☐	HIV Positive
☐	☐	Muscle Aches	☐	☐	Cancer
☐	☐	Trouble Walking	☐	☐	Depression
☐	☐	Hip/Knee Replacement	☐	☐	Alcohol Use
☐	☐	Fainting	☐	☐	High Blood Pressure
☐	☐	Gall Bladder Problems	☐	☐	Stroke History
☐	☐	Ringing in the Ears	☐	☐	High Cholesterol
☐	☐	Ear Problems	☐	☐	TMJ
☐	☐	Sleeping Problems	☐	☐	Digestive Problems
☐	☐	Vision Problems	☐	☐	Pain All Over
☐	☐	Thyroid Problems	☐	☐	Tension/Irritability
☐	☐	Liver Disease	☐	☐	Chest Pains
☐	☐	Kidney Problems	☐	☐	Heart Pacemaker
☐	☐	Light Bothers Eyes	☐	☐	Heart Problems

List all if the medications that you are taking:_____

_____

List all of the doctors that you are currently seeing: _____

_____

Notes:_____

PAST HISTORY

List any past auto collisions: _____ ☐received care ☐no care

List any past work injuries: _____ ☐received care ☐no care

List any past sport, recreational, or home injuries:_____

Please describe any past conditions and treatments received: _____

_____

Please list any past hospitalizations and surgeries: _____

_____

FAMILY HISTORY

Father's side: ☐Heart Disease ☐Cancer ☐Diabetes ☐Heavy Medication use ☐Arthritis ☐Other _____

Mother's side: ☐Heart Disease ☐Cancer ☐Diabetes ☐Heavy Medication use ☐Arthritis ☐Other _____

Is there any other family history that you would like us to know about?_____

_____