Patient Name______________________________ Date______________________

VAIL CHIROPRACTIC CLINIC PLLC
PATIENT CONFICENTIAL HEALTH HISTORY

The items below may relate to your current condition. Please enter (Y) if you have ever had the problem.

GENERAL

1. ______ Fever
2. ______ Chills
3. ______ Night Sweats
4. ______Loss of Sleep
5. ______Fatigue
6. ______Nervousness
7. ______Weight Loss or Gain
8. ______Bleeding Problems
9. ______Anemia
10. _____Anemia
11. _____Diabetes
12. _____Cancer
13. ____Thyroid Disease/Goiter
14. _____Alcoholism
15. _____Drug Abuse

EAR, EYE, NOSE, THROAT

16. _____Poor Vision
17. _____Pain in Eye
18. _____Deafness/Difficulty Hearing
19. _____Nosebleeds
20. _____Nose Problems
21. _____Sinus Problems
22. _____Dental Problems
23. _____Hoarseness
24. _____Tonsillectomy

GASTROINTESTINAL

25. _____Poor Appetite
26. _____Poor Digestion
27. _____Difficulty Swallowing
28. _____Belching or Gas
29. _____Frequent Nausea
30. _____Vomiting
31. _____Vomiting Blood
32. _____Pain over Abdomen
33. _____Ulcer
34. _____Black or Bloody Stool
35. _____Liver Problems
36. _____Gall Bladder Problems
37. _____Jaundice
38. _____Hernia
39. _____Diarrhea
40. _____Constipation
41. _____Hypothermia
42. _____Appendicitis

MEN ONLY

43. _____Testicular Swelling/Pain
44. _____Prostate Problems

RESPIRATORY

45. _____Difficulty in Breathing
46. _____Chronic Cough
47. _____ Spitting Phlegm
48. _____Spitting Blood
49. _____ Wheezing/Asthma
50. _____Pneumonia
51. _____Tuberculosis

CARDIOVASCULAR

52. _____Irregular Heartbeat
53. _____High Blood Pressure
54. _____Pain Over Heart
55. _____Previous Heart Trouble
56. _____Ankle Swelling
57. _____Varicose Veins
58. _____Rheumatic fever
59. _____Stoke

GENITOURINARY

60. _____Frequent Urination
61. _____Painful Urination
62. _____Blood in Urine
63. _____Kidney Disease
64. _____Urinary Infection
65. _____Inability to Control Urination
66. _____Difficulty Starting Urine Flow
67. _____Get up at night to Urinate
68. _____Breast Lump or Pain
69. _____Venereal Infection
70. _____Sexual Difficulties

SKIN

71. _____Itching
72. _____Busing Easily
73. _____Change in Moles
74. _____Skin Cancer
75. _____Scars Location

NERROLOGIC

76. _____Weakness
77. _____Twitching
78. _____Tremors
79. _____Headaches
80. _____Fainting
81. _____Dizziness
82. _____Convulsions
83. _____Epilepsy/Seizures
84. _____Numbing/Tingling
85. _____Arm/Leg Pain
86. _____Mental Disorder

MUSCULOSKELETAL

87. _____Neck Stiffness/Pain
88. _____Pain Between Shoulders
89. _____Low Back Pain
90. _____Swollen Joints
91. _____Painful Joints
92. _____Muscle Aches/Soreness
93. _____Spinal Curvature
94. _____Arthritis

WOMEN ONLY

95. _____Painful Periods
96. _____Excessive Flow
97. _____Irregular Cycles
98. _____Vaginal Burning/Itching
99. _____Hot Flashes
100. ____Date of Last Period
101. ____Date of last Pap Smear

EXERCISE

102. ____None
103. ____1-2 times/week
104. ____2-4 times/week
105. ____6-7 times/week

HABITS

106. ____Smoking____#packs
107. ____Drinking
108. ____Recreational Drug Use
109. ____Caffeine

FAMILY HISTORY
DO NOT INCLUDE YOURSELF
Include information on brothers, sisters, parents, and grandparents

110. ____Diabetes
111. ____Thyroid Disease/Goiter
112. ____Tuberculosis
113. ____Kidney Disease
114. ____ High Blood Pressure
115. ____Heart Disease
116. ____Caner
117. ____Muscle, Bone or nerve Disease
118. ____Lung Disease
119. ____Ulcers
120. ____Arthritis
121. ____Seizures/Strokes

MISCELLANEOUS

____
____