Rosenthal Chiropractic, P.A. 507 S. Maryland Ave. Wilmington, DE 19804 302-999-0633

CONFIDENTIAL HEALTH HISTORY

Name_____ **Date**_____

In the box in front of each item, enter (x) if you currently have or had in the past the problem. Please leave the box blank if it does not apply. Past conditions are marked in the first box and Current conditions in the second.

GENERAL

Past	Current	
☐	☐	Fever
☐	☐	Chills
☐	☐	Night Sweats
☐	☐	Loss of sleep
☐	☐	Fatigue
☐	☐	Nervousness
☐	☐	Weight Loss/Gain
☐	☐	Allergies
☐	☐	Bleeding Problem
☐	☐	Anemia
☐	☐	Diabetes
☐	☐	Cancer
☐	☐	Thyroid
☐	☐	Disease/Goiter
☐	☐	Alcoholism
☐	☐	Drug Abuse
☐	☐	HIV positive
☐	☐	Other_____

☐ **None of the above**

EYE EAR NOSE THROAT

Past	Current	
☐	☐	Poor Vision
☐	☐	Pain in Eye(s)
☐	☐	Poor Hearing/Deaf
☐	☐	Nosebleeds
☐	☐	Nose Problems
☐	☐	Sinus Trouble
☐	☐	Dental Problems
☐	☐	Hoarseness
☐	☐	Tonsillectomy
☐	☐	Other_____

☐ **None of the above**

GASTROINTESTINAL

Past	Current	
☐	☐	Poor Appetite
☐	☐	Poor Digestion
☐	☐	Difficulty Swallowing
☐	☐	Belching or Gas
☐	☐	Frequent Nausea
☐	☐	Vomiting
☐	☐	Vomiting Blood
☐	☐	Pain over Abdomen
☐	☐	Ulcer
☐	☐	Black or Bloody Stools
☐	☐	Liver Problems
☐	☐	Gall Bladder Problems
☐	☐	Jaundice
☐	☐	Hernia
☐	☐	Diarrhea
☐	☐	Constipation
☐	☐	Hemorrhoids
☐	☐	Appendicitis
☐	☐	Other_____

☐ **None of the above**

RESPIRATORY

Past	Current	
☐	☐	Difficult Breathing
☐	☐	Chronic Cough
☐	☐	Spitting Phlegm
☐	☐	Spitting Blood
☐	☐	Asthma/Wheezing
☐	☐	Pneumonia
☐	☐	Tuberculosis
☐	☐	Other_____

☐ **None of the above**

CARDIOVASCULAR

Past	Current	
☐	☐	Irregular Heartbeat
☐	☐	High blood pressure
☐	☐	Pain over Heart
☐	☐	Previous Heart
☐		Trouble
☐	☐	Ankle Swelling
☐	☐	Varicose Veins
☐	☐	Rheumatic Fever
☐	☐	Stroke
☐	☐	Other_____

☐ **None of the above**

GENITOURINARY

Past	Current	
☐	☐	Frequent Urination
☐	☐	Painful Urination
☐	☐	Blood in Urine
☐	☐	Kidney Disease
☐	☐	Urinary Infection
☐	☐	Inability to Control Urination
☐	☐	Breast Lump or Pain
☐	☐	Venereal Infection
☐	☐	Sexual Difficulties
☐	☐	Other_____

☐ **None of the above**

SKIN

Past	Current	
☐	☐	Itching
☐	☐	Bruising easily
☐	☐	Change in Mole(s)
☐	☐	Dryness/Wetness
☐	☐	Change in color
☐	☐	Skin Cancer
☐	☐	Other_____

☐ **None of the above**

WOMEN ONLY

Past	Current	
☐	☐	Live births
☐	☐	Miscarriage
☐	☐	Painful Periods
☐	☐	Excessive Flow
☐	☐	Irregular Cycles

☐ **None of the above**

WOMEN ONLY

Past	Current	
☐	☐	Vaginal Burning/Itching
☐	☐	Hot Flashes

☐ **None of the above**

MEN ONLY

Past	Current	
☐	☐	Testicular Swelling/Pain
☐	☐	Prostate problems
☐	☐	Other_____

☐ **None of the above**

NEUROLOGICAL

Past	Current	
☐	☐	Weakness
☐	☐	Twitching
☐	☐	Tremors
☐	☐	Headache
☐	☐	Fainting
☐	☐	Dizziness
☐	☐	Convulsions
☐	☐	Epilepsy
☐	☐	Numbness/Tingling
☐	☐	Arm/Leg Pain
☐	☐	Mental Disorder
☐	☐	Other_____

☐ **None of the above**

MUSCULOSKELETAL

Past	Current	
☐	☐	Swollen Joints
☐	☐	Spinal Curvature
☐	☐	Arthritis
☐	☐	Painful Joints
☐	☐	Muscle Aches/Soreness
☐	☐	Other_____

☐ **None of the above**

CHILDHOOD DISEASES

☐ Mumps
☐ Measles
☐ Chickenpox
☐ Other_____

☐ **None of the above**

SURGERIES

☐ **None**

List dates and reasons:

_____
_____
_____
_____

HOSPITALIZATIONS

☐ **Never Hospitalized**

List dates and reasons

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

HABITS/ADDICTIONS

☐ Smoking_____packs/day
☐ Alcohol
☐ Coffee
☐ Tea with caffeine
☐ Soft drinks
☐ Other_____

☐ **None of the above**

SLEEP

Hours per night_____

STRESS LEVELS

☐ High ☐ Medium
☐ Low ☐ None

EXERCISE

☐ None
☐ ____times per week
Type_____

ANY OTHER HEALTH CONCERNS?

☐ **None**

_____
_____
_____
_____
_____
_____

Notes:

Reviewed by:

_____

Scott Rosenthal, D.C.