PHILADELPHIA · COLLEGE · OF · OSTEOPATHIC · MEDICINE

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?_____
Is today's visit related to a motor vehicle accident? Yes No

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?_____
_____
_____

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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:_____

_____

_____

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	Chest pain	Headache
Fever	Abdominal pain	Cold intolerance
Night sweats	Loss of appetite	Back pain
Ear pain	Urinary incontinence	Joint pain
Eye pain	Rash	Neck pain
Cough	Extremity numbness	Easy bleeding
Problems breathing	Extremity weakness	Seasonal allergies

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_____