Health History Inventory

Name:_____ Date:_____

Please mark an X in the boxes below if you have ever experienced the following:

Head/Ear/Nose/Throat
- ☐ Tension headaches
- ☐ Migraine headaches
- ☐ Cluster headaches
- ☐ Concussion or head trauma
- ☐ Jaw pain
- ☐ Hearing impairment
- ☐ Seizures or Epilepsy
- ☐ Tinnitus (ringing in ears)
- ☐ Sinus congestion/infections
- ☐ Teeth grinding or clenching
- ☐ Dizziness
- ☐ Visual impairment

Musculoskeletal
- ☐ Back pain or Sciatica
- ☐ Mid back pain
- ☐ Neck pain
- ☐ Rheumatoid arthritis
- ☐ Osteoarthritis
- ☐ Tendonitis or Bursitis
- ☐ Carpal tunnel syndrome
- ☐ Bone fracture
- ☐ Pain in elbows, wrists or hands
- ☐ Pain in hips, knees or feet

Respiratory
- ☐ Shortness of breath
- ☐ Asthma, Emphysema or Bronchitis
- ☐ Tuberculosis or Pneumonia
- ☐ Frequent colds
- ☐ Chronic cough
- ☐ Smoker

Digestive
- ☐ Liver disease or hepatitis
- ☐ Heartburn/Indigestion/Reflux
- ☐ Abdominal distension/bloating
- ☐ Diarrhea or loose stools
- ☐ Constipation or dry stools
- ☐ Gall bladder disorder or stones
- ☐ Irritable bowel syndrome
- ☐ Colitis/Crones/Celiac disease
- ☐ Hernia
- ☐ Diabetes
- ☐ Nausea

Genitourinary
- ☐ Urinary or bladder disorder
- ☐ Kidney disorder or stones
- ☐ Premenstrual syndrome
- ☐ Painful or irregular periods
- ☐ Heavy flow
- ☐ Menopausal (or pre/post)
- ☐ Prostate or genital disorder
- ☐ Pregnancies (#) _____
- ☐ Children (#) _____
- ☐ Currently pregnant (due date)

Cardiovascular
- ☐ Coronary/Artery disease
- ☐ Heart attack/chest pain
- ☐ Stroke/Aneurism
- ☐ Pacemaker
- ☐ High/Low blood pressure
- ☐ Varicose veins
- ☐ High cholesterol
- ☐ Heart palpitations
- ☐ Swelling in legs/ankles/feet
- ☐ Hemorrhoids
- ☐ Hemophilia

Endocrine
- ☐ Thyroid disorder
- ☐ Menopause symptoms
- ☐ Insomnia or poor sleep
- ☐ Hours of sleep per night ____
- ☐ Eating habits (poor/fair/good)
- ☐ Night sweats
- ☐ Exercise (___x per week)

Psychological
- ☐ Attention deficit disorder
- ☐ Panic, anxiety or phobias
- ☐ Depression or bipolar disorder
- ☐ Difficulty making decisions
- ☐ Poor memory
- ☐ Mental confusion
- ☐ Bored or uninterested in things
- ☐ Thoughts of killing yourself
- ☐ Substance abuse
- ☐ Other_____

Dermatology
- ☐ Dermatitis, Eczema or Hives
- ☐ Allergies or hay fever
- ☐ Dry skin
- ☐ Psoriasis

Neurological
- ☐ Multiple Sclerosis
- ☐ Polio
- ☐ Muscle tremors or tics
- ☐ Radiating pain
- ☐ Tingling
- ☐ Numbness
- ☐ Paralysis

Cancer (please elaborate)

Surgeries (please elaborate)

Other
- ☐ Anorexia or bulimia
- ☐ Chronic Fatigue Syndrome
- ☐ Mononucleosis
- ☐ Fibromyalgia
- ☐ Lethargy, lassitude or tiredness
- ☐ Aids or HIV
- ☐ Shingles
- ☐ Overstressed