Specialized Medicine

BOLTZ

PAIN AND WELLNESS CENTER

HEALTH HISTORY QUESTIONNAIRE

Patient Name ______________________________

Today's Date ____________ Date of Birth ____________

Signature ______________________________

Age: __________ Sex: Male Female

What treatment have you received for your condition?

Oral Steroids | Chiropractic Care | Narcotics | Prescription medicine | Physical Therapy

Massage | Acupuncture | Other ______________________________

Epidural/Facet Injection | Where ____________ | When ____________ | Doctor ____________

Neck Back Surgery | Where ____________ | When ____________ | Doctor ____________

Please check to indicate if you have history of the following...

Anemia	Arthritis	Asthma	Blood Disorder	COPD	Diabetes	Emphysema
Kidney Disease	Liver Disease	Epilepsy	Fibromyalgia	Stroke	Heart Disease	Hepatitis
Osteoporosis	Pacemaker	Lung Disease	Diabetes	Thyroid Problems	Sleep Apnea	Stint
High Blood Pressure	Migraine Headaches	Parkinson's Disease	Multiple Sclerosis	Rheumatoid Arthritis	Chemical Dependency	
Gastro Esophageal Reflux Disease		Pulmonary Vascular Disease		Cancer -- Location: ____________		

Are you taking a blood thinner? No Plavix Coumadin Aspirin Other: ____________________

Please list all medications.

Medication/ Dosage/ Frequency

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Are you currently taking an antibiotic for infection? Yes No

Last dose? ____________________

Please list and date ALL surgeries. List any additional on back

Tonsillectomy
Hysterectomy
Gallbladder Removal
Appendix Removal
Hernia Repair
Heart Bypass # of vessels ________
Pacemaker
Skin Cancer
Carpal Tunnel
Joint Replacement ____________
Stint

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Family History

Father's Side		Mother's Side
	Heart Disease	
	High Blood Pressure	
	Stroke	
	Cancer	
	Diabetes	
	Bleeding Disorder	
	Kidney Disease	
	Thyroid Disease	
	Epilepsy	
	Osteoporosis	
	Glaucoma	

Please list all know drug allergies

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Latex Betadine Tape IVP Dye

Height __________ Weight __________

For Office Use Only

T: ________ BP: __________ HR: _________ O2sat: ________

CC: ______________________________

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Mode of Ambulation: Self Cane Crutches Walker Wheelchair