INITIAL HEALTH HISTORY FORM

Michiana Spine, Sports & Occupational Rehab, P.C.
3740 Edison Lakes Parkway, Mishawaka, IN 46545 Toll Free (888) 734-2246 Fax (574) 252-4161
Kevin G. Drew, MD, John L. Kittredge, PA-C, Alessandra Chatson, FNP

Name:_____ Date of Birth:_____/_____/_____ Today's Date:_____/_____/_____

What is your reason for this visit? _____

_____

_____

MEDICATIONS: *Please list the medications you are taking, along with doses and times per day.*_____

_____

_____

_____

_____

ALLERGIES: *Please list the medications you allergic to or have had reactions to.* _____

_____

_____

PAST MEDICAL HISTORY: *please check the conditions you have had.*

□ AIDS/HIV	□ Chemical Dependency	□ Hepatitis A B C	□ Pneumonia
□ Alcoholism	□ Depression	□ Hernia	□ Polio
□ Anemia	□ Diabetes	□ Herpes	□ Prostate Problem
□ Anorexia	□ Emphysema	□ High Blood Pressure	□ Psychiatric Care
□ Arthritis	□ Epilepsy	□ High Cholesterol	□ Stroke
□ Asthma	□ Fibromyalgia	□ Kidney Disease	□ Suicide Attempt
□ Bleeding Disorders	□ Glaucoma	□ Liver Disease	□ Thyroid Problems
□ Breast Lump	□ Goiter	□ Migraine Headaches	□ Tuberculosis
□ Bulimia	□ Gonorrhea	□ Multiple Sclerosis	□ Typhoid Fever
□ Cancer	□ Gout	□ Osteoporosis	□ Ulcers
□ Cataracts	□ Heart Disease	□ Pacemaker / Defibrillator	□ Other_____

HOSPITALIZATIONS AND SURGERIES:

Date/Year	Hospital / Physician	Reason for Hospitalization or Type of Surgery

INJURIES OR ACCIDENTS: *Please list any serious injuries or accidents you have had.*_____

_____

_____

HEALTH HABITS: *Check* (√) if you are using the following or have ever used them.

Present Use	Past Use	Substance	Frequency
		Alcohol	
		Caffeine	
		Tobacco	Packs/day: Years Smoking:
		Street Drugs	List with frequency:

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FAMILY HISTORY:

Relation	Age	State of Health	Age at Death	Cause of Death	Check (√) if your blood relative had any of the following:	Disease	Relation to you
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Strokes	
Sisters						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	

LEGAL ISSUES: *Have you been involved in legal issues involving drugs or alcohol?* ☐ Yes. ☐ No. *Please describe:*_____
_____

WORK: Do you work now? Yes No. How long? _____ years. Job title: _____Employer: _____
If not working, when did you last work? _____ Why did you stop working?_____
_____
Check if your work exposures you to any of the following: □ Stress, □ Heavy lifting, □ Hazardous Substances

Signatures: To the best of my knowledge, the information I have given is complete and accurate. I understand it is my responsibility to inform my health care providers if there is a change in my health or medications.

Signature of patient or representative: _____ Date: _____/_____/_____

Print name of patient representative: _____

Reviewed by: _____ Date: _____/_____/_____