

Name: _____

Date: _____

DuPage Neurology & Wellness Center Health History Form

PART I Social History

Alcoholic beverages consumed per week? _____	The three worst foods you eat during the average week? _____
Caffeinated beverages consumed per day? _____	_____
Times you eat out per week? _____	_____
Times per week you eat raw nuts or seeds? _____	_____
Times per week you eat fish? _____	_____
Times per week you workout? _____	The three healthiest foods you eat during the average week? _____
Do you smoke? _____ yes / no	_____
If yes, times per day _____ per week _____	_____
Do you use recreational drugs? _____ yes / no	_____
If yes, which type? _____	Are you on a low-fat diet? _____ Yes / No
Times per day _____ per week _____	Ever taken GABA to help you fall asleep? _____ Yes / No
Stress levels (1-10) during the average week. _____	If yes, did it work? _____ Yes / No
Do you use skin creams? _____ yes / no	What is your favorite food? _____

Please list any natural supplements you currently take and for what conditions:

Part II Medication History

Please indicate if in the past 5 years you have taken, or are currently taking any of the following classes of medication (label "c" for current, "p" for previous and designate duration):

<input type="checkbox"/> Antacids	<input type="checkbox"/> Insulin Support Agents	<input type="checkbox"/> Oral Contraceptives
<input type="checkbox"/> Antibiotics	<input type="checkbox"/> NSAIDS/Anti- inflammatory agents	<input type="checkbox"/> Hormones
<input type="checkbox"/> Antifungals	<input type="checkbox"/> Anxiety Medications	<input type="checkbox"/> Laxatives
<input type="checkbox"/> Antihistamines	<input type="checkbox"/> Blood pressure lowering agents	<input type="checkbox"/> Diuretics
<input type="checkbox"/> Antidepressants	<input type="checkbox"/> Cholesterol lowering agents	<input type="checkbox"/> Cortisone (cream, injection, or pill)

Please list any other medications you are taking, including over-the-counter meds. Also indicate the reason for taking and length of time you have been on each medication.

Part III Review of Systems-Check all that apply

Eyes/Vision

<input type="checkbox"/> Wear glasses/contacts	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Recent change in vision	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Macular Degeneration

Respiration

<input type="checkbox"/> Cough	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Excessive sputum production	

Cardiovascular

<input type="checkbox"/> Chest pain/discomfort	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Swelling in feet/ankles
<input type="checkbox"/> Leg pain/ache	<input type="checkbox"/> Rapid pulse	<input type="checkbox"/> Difficulty breathing when lying down
<input type="checkbox"/> Heaviness in legs	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Wake at night with shortness of breath
<input type="checkbox"/> Pain in shoulder/jaw	<input type="checkbox"/> Low blood pressure	
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Varicose veins	

Skin

<input type="checkbox"/> Unusual pattern of hair growth	<input type="checkbox"/> Hives	<input type="checkbox"/> Rash
<input type="checkbox"/> Changes in skin color	<input type="checkbox"/> Sore that won't heal	<input type="checkbox"/> Eczema
<input type="checkbox"/> Changes in wart/mole	<input type="checkbox"/> Itching	<input type="checkbox"/> Skin lesions/ulcers

Hematologic

<input type="checkbox"/> Unusual bleeding/discharge	<input type="checkbox"/> History of blood transfusion	<input type="checkbox"/> Swelling of lymph nodes
<input type="checkbox"/> Problems with blood clotting	<input type="checkbox"/> Bruise easily	

Name: _____

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Part IV Medical History

Please indicate if you have, or have ever had, any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Kidney disease/stones | <input type="checkbox"/> Skin cancer |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Learning disability | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Thrombophlebitis |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Type II Diabetes |

Section A1

- | | | |
|--|--|---|
| <input type="checkbox"/> Alopecia Areata | <input type="checkbox"/> Lupus Erythematosus (SLE) | <input type="checkbox"/> Sjogren's Syndrome* |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Multiple Sclerosis* | <input type="checkbox"/> Temporal Arteritis |
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Myasthenia Gravis* | <input type="checkbox"/> Type I Diabetes |
| <input type="checkbox"/> Crohn's Disease* | <input type="checkbox"/> Narcolepsy | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Dermatomyositis | <input type="checkbox"/> Pernicious Anemia | <input type="checkbox"/> Vasculitis |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Psoriasis* | <input type="checkbox"/> Vitiligo |
| <input type="checkbox"/> Grave's Disease | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Wegener's Granulomatosis |
| <input type="checkbox"/> Hashimoto's disease | <input type="checkbox"/> Schizophrenia* | |
| <input type="checkbox"/> Interstitial Cystitis | <input type="checkbox"/> Scleroderma | |

Section C

- | | | |
|---|---|---|
| <input type="checkbox"/> Addison's Disease | <input type="checkbox"/> Eczema | <input type="checkbox"/> Migraines or headaches |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Non-Hodgkin's Lymphoma |
| <input type="checkbox"/> Ataxia/Nerve Disease/Neuropathy | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Numbness/tingling in extremities |
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Flatulence (Gas) | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Osteopenia/-porosis |
| <input type="checkbox"/> Bacterial Overgrowth (Intestinal) | <input type="checkbox"/> Gastrointestinal Bleeding | <input type="checkbox"/> Pancreatic Disorders |
| <input type="checkbox"/> Bloating, gas, or stomach cramping | <input type="checkbox"/> Growth Hormone Deficiency | <input type="checkbox"/> Peripheral Neuropathy |
| <input type="checkbox"/> Candida Albicans | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Psychiatric disorders |
| <input type="checkbox"/> Canker Sores | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Sarcoidosis |
| <input type="checkbox"/> Casein/Lactose Intolerance | <input type="checkbox"/> Infertility/Miscarriage | <input type="checkbox"/> Sepsis |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Cognitive Impairment | <input type="checkbox"/> Intestinal Permeability | <input type="checkbox"/> Small Intestinal Cancer |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Thrombocytopenic Purpura |
| <input type="checkbox"/> Diarrhea or runny stools | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid disorders |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lactose Intolerance | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Dermatitis Herpetiformis | <input type="checkbox"/> Liver Disease | |
| <input type="checkbox"/> Dyspepsia/Acid Reflux | <input type="checkbox"/> Malnutrition | |

Note if anyone in your family had any of the above conditions (* item if it was cause of death)

Please indicate any hospitalizations/surgery you have undergone:

Are you seeing a doctor now for any reason? Yes / No If so, indicate why: _____

Name/address of Primary Care Physician: _____

Have you ever seen a chiropractor before? Yes / No

If yes, for what problem? _____ Were the results satisfactory? Yes / No

Please describe treatment: _____

Do you have any allergies (food, prescription drug, seasonal, etc)? Yes / No

(Signature/date)