OSTEOPATHIC HEALTHCARE OF MAINE
ADULT HEALTH HISTORY

Legal name : _____ DOB:_____ Date :_____
Preferred name (nick name):_____ Gender at birth:_____
Who referred you? _____

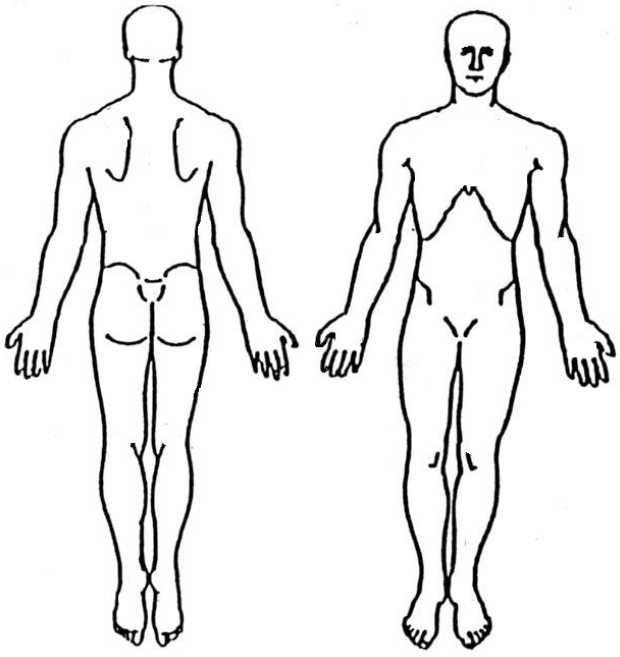
Problem	Location	How Long?
1.		
2.		
3.		
4.		

Describe what caused the problem and what makes it better or worse:

1._____
_____
2._____
_____
3._____
_____
4._____
_____

Symptom Drawing
Please mark the areas on the diagrams below where you feel symptoms, using the codes indicated. Include all the affected areas.

Ache	Sharp	Tight/Stiff	Pressure	Numb	Burning	Tingling
~~	>>>>	/////	++++	oooo	xxxx	****
~~	>>>>	/////	++++	oooo	xxxx	****



How bad is your pain on an average day?

None_____Worst
0 1 2 3 4 5 6 7 8 9 10

Review Of Systems

General
____ Fatigue
____ Fever
____ Chills
____ Sleep Problems

Nutritional
____ Weight loss
____ Weight gain
____ Poor appetite

Head
[ ] Headaches
[ ] Migraines
[ ] Head injuries
[ ] Head pain

Eyes
[ ] Discharge
[ ] Eye pain
[ ] Visual problem
[ ] Visual change
[ ] Dry eye

Nose
[ ] Nose bleeds
[ ] Congestion
[ ] Frequent URI
[ ] Nasal Obstruction
[ ] Sinus Infection

Mouth
[ ] Bleeding gums
[ ] Dental problems
[ ] Dental procedures
[ ] Root canals
[ ] Pain

Ears
[ ] Hearing impairment
[ ] Ear infection
[ ] Ringing in ears
[ ] Pain

Throat
[ ] Frequent sore throats
[ ] Pain
[ ] Postnasal drip
[ ] Hoarseness/change in voice
[ ] Swallowing problems

Respiratory
[ ] Wheezing
[ ] Asthma
[ ] Cough
[ ] Shortness of breath
[ ] COPD

Cardiovascular
[ ] High blood pressure
[ ] Chest pain
[ ] Heart disease
[ ] Palpitations
[ ] Irregular heartbeat

Gastrointestinal
[ ] Abdominal pain
[ ] Constipation
[ ] Diarrhea
[ ] Nausea
[ ] Vomiting
[ ] Bloating
[ ] Heartburn/reflux

Musculoskeletal
[ ] Joint pain
[ ] Muscle stiffness/pain
[ ] Muscle weakness
[ ] Muscle cramps/spasms

Psychiatric
[ ] Anxiety
[ ] Depression
[ ] Panic attacks
[ ] PTSD
[ ] Past/present psychiatric diagnosis

Skin
[ ] Itching
[ ] Rash
[ ] Eczema
[ ] Psoriasis
[ ] Acne/rosacea

Neurological
[ ] Numbness
[ ] Tingling
[ ] Dizziness/vertigo
[ ] Dizziness/vertigo w/ positional change

Endocrine
[ ] Thyroid problems
[ ] Diabetes
[ ] PMS
[ ] Hormone therapy
[ ] Adrenal problems
[ ] Hot flashes

Hematologic/Lymph
[ ] Swollen glands
[ ] Blood clots
[ ] Easy bruising
[ ] Clotting disorder
[ ] Anemia

Allergies/Immune
[ ] Sneezing
[ ] Hives
[ ] Itching/watery eyes
[ ] Dust/environmental allergies
[ ] Food allergies
[ ] Vaccine reaction

Genitourinary Female
[ ] UTI
[ ] Bladder/urinary irritation
[ ] Fertility problems
[ ] Menopause
[ ] Dysmenorrhea/painful menses
[ ] Endometriosis
[ ] Ovarian problems

Genitourinary Male
[ ] UTI
[ ] Bladder/urinary irritation
[ ] Fertility problems
[ ] Hernia
[ ] Prostate problems
[ ] ED
[ ] Changes in urination

Other symptoms not listed:
[ ]_____

[ ]_____

[ ]_____

[ ] Not experiencing any symptoms

Diagnostic Testing:

(I.E: XRAY, CAT SCAN, MRI, BONE SCAN, EMG, BONE DENSITY, EEG, PFT, BLOOD, URINE TESTS) None: [ ]

Please list date, body area and result of imaging report or test

1. _____
2. _____
3. _____
4. _____

Allergies/sensitivities: None: [ ]

Please list any reactions you have to medications, foods, environment, or chemicals, date of onset and the reaction you have.

Allergy	**Date Started** (if known)	**Reaction**

Medications: None:[ ]

Please list all medications, date started, and dosage information. Include all prescriptions, supplements, and homeopathic remedies.

Prescription/Supplement/Name	**Date started**	**Dosage**

VITAL SIGNS: **Height: _____ ft _____ in** **Weight: _____ lbs**

Family History:

Relative	Age	Gender	Medical Problems	Check if deceased	Cause of Death
Father					
Mother					

Health Problems in Blood Relatives:

[ ] Chronic Back pain [ ] Ruptured Discs [ ] Fibromyalgia [ ] Thyroid Disease [ ] Depression

[ ] Anxiety [ ] ADD/ADHD [ ] Autoimmune Disease [ ] Heart Disease [ ]Obesity

[ ] Substance Abuse [ ] Cancer [ ] Lyme/Co Infection Disease [ ] Other:_____

Past Medical History:
(Please give details and approximate dates)

Trauma: None: [ ]

1. Head trauma/concussion:_____
2. Motor Vehicle Accident:_____
3. Injuries (sports, falls, repetitive use, etc):_____
4. Physical demanding activities (sports, arts, crafts, etc.):_____
5. Dental work (implants, braces, Invisalign, etc.):_____
6. Emotional trauma:_____
7. Root Canal/Dental Extraction:_____
8. Other:_____

Illness/Disease Process

[ ] Arthritis	[ ] Irritible Bowel Syndrome	[ ] Cancer
[ ] Carpal Tunnel Syndrome	[ ] Gerd/reflux	[ ] High Cholesterol/Triglycerides
[ ] Disc Disease	[ ] Crohns/ Ulc. Colitis	[ ] Auto Immune Disease
[ ] Lyme Disease	[ ] Eating disorders	[ ] Other:_____
[ ] Fibromyalgia	[ ] Obesity	[ ] Other:_____
[ ] Chronic Fatigue Syndrome	[ ] Thyroid disease	[ ]Other:_____
[ ] ADD/ADHD	[ ] Neuralgia/Neuropathy	[ ]Other:_____
[ ] Depression	[ ] Bell's Palsy	[ ]Other:_____
[ ] Anxiety	[ ] Vertigo/tinnitus	[ ]Other:_____
[ ] High Blood Pressure	[ ] Diabetes mellitus	[ ]Other:_____

WOMEN ONLY:

Obstetric History:

Total # of pregnancies	**Living children**
Abortions	**Miscarriages**
Full term deliveries	**Premature deliveries**

Birth Date	Prenatal Problems	Duration of labor	Delivery Type	Procedure Complications	Postpartum Problems

Social History:

Home Environment

Who lives in home with you?_____

How's your quality of home life?_____

Environmental exposures (including smokers, pets)?_____

Are you Single [ ] Married [ ] Divorced [ ] Widow [ ] Separated [ ]

Work Environment:

What is your current work title?_____

What is your job responsibilities/satisfaction?_____

Physical demands/ergonomics?_____

Prior job history?_____

Habits

Habit	Amount	Frequency	For how many years	When quit	Never
Smoking					
Alcohol					
Drugs					
Caffeine					
Medical Cannabis					

Health Maintenance:

Physical activity/exercise (type/frequency)_____

Favorite Hobbies_____

Fluid intake (type/amount per day)_____

Sleep/rest (quality of sleep, how many hours per day) _____

Diet: [ ] Organic [ ] Gluten Free [ ] Diary Free [ ] Vegetarian [ ] Other _____

Surgical History:

[ ] Disc/Laminectomy [ ] Fracture Repair [ ] Ligament Repair [ ] Scoliosis [ ] Spinal Fusion [ ] C-Section [ ] Joint replacement

[ ] Gallbladder [ ] Appendix [ ] Prostate [ ] Breast [ ] Sinus [ ] Ear [ ] Nose [ ] Tonsils/Adenoids [ ] Dental [ ] Angioplasty

[ ] Bypass [ ] Laparoscopic procedures [ ] Cosmetic [ ] Breast Augmentation [ ] Dental Implants

[ ] Other: _____

Hospitalizations:

Hospital	Dates	Diagnosis	Treatment

Any additional information you would like to share?_____