Cole Center for Healing, Inc.
7760 W. VOA Park Dr., Suite C
West Chester, Ohio 45069
513-563-4321

HEALTH HISTORY

Date:_____

Patient Name:_____ Date of birth:_____

Chief Complaint: _____

History of present illness:

Location:_____ Quality: _____
(Where is pain/problem?) (Example: normal vs abnormal color, activity, etc)

Severity: _____ Duration_____
(How severe is pain/problem on scale of 1-5, 5 being most severe?) (How long have you had pain/problem? When did it start?)

Timing: _____ Context: _____
(Does pain/problem occur at specific time?) (Where were you at onset of this pain/problem?)

Associated signs/symptoms:_____ Modifying Factors:_____

_____ _____
(What other associated problems have you been having?) (What makes pain/problem worse/better? Have you had previous episodes?)

Past Medical History

Have you ever had the following (Place X in correct box, leave blank if NA or uncertain

	Yes	No		Yes	No		Yes	No
Measles	____	____	Diabetes	____	____	Mitral Valve Prolapse	____	____
Mumps	____	____	Cancer	____	____	Back Trouble	____	____
Chickenpox	____	____	Polio	____	____	Stroke	____	____
Whooping Cough	____	____	Glaucoma	____	____	Hepatits	____	____
Scarlet Fever	____	____	Hernia	____	____	Kidney Disease	____	____
Diptheria	____	____	Migraine Headaches	____	____	Ulcer	____	____
Smallpox	____	____	Blood or Plasma			Thyroid Disease	____	____
Pneumonia	____	____	Transfusion	____	____	Bleeding Tendency	____	____
Rheumatic Fever	____	____	Low Blood Pressure	____	____	Date of last X-ray	_____	
Heart Disease	____	____	High Blood Pressure	____	____	Any Other Disease	____	____
Arthritis	____	____	Hemorrhoids	____	____	Please List:	_____	
Venereal Disease	____	____	Asthma	____	____	_____		
Bladder Infections	____	____	Hives or Eczema	____	____	_____		
Epilepsy	____	____	Aids or HIV	____	____	_____		
Anemia	____	____	Infectious Mono	____	____	_____		
Tuberculosis	____	____	Bronchitis	____	____	_____		

Previous Hospitalizations/Surgeries/Serious Illnesses? _____
_____
_____When?_____ Hospital, City, State _____

Medications(Include nonprescription)_____
_____

Patient Social History: (place X in appropriate box(s)

Marital Status: Single _____ Married_____ Separated_____ Divorced_____ Widowed_____
Use of Alcohol: Never _____ Rarely _____ Moderate _____ Daily _____
Use of Tobacco Never _____ Previously, but quit _____ Current packs/day _____
Use of Drugs Never _____ Type/Frequency_____
Excessive exposure at home or work to: Airborne
Fumes _____ Dust _____ Solvents _____ Particles _____ Noise _____

Family Medical History:

	Age	Diseases	If Deceased, cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Sibling	_____	_____	_____
Sibling	_____	_____	_____
Sibling	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

Review of Systems: Please indicate any personal history below:

Constitutional Systems	**Yes**	**No**
Good General Health	____	___
Recent Weight Change	____	____
Fever	____	____
Fatigue	____	____
Headaches	____	____
Eyes		
Eye disease or injury	____	____
Wear glasses/contacts	____	____
Blurred/double vision	____	____
Ears/Nost/Mouth/Throat		
Hearing Loss or ringing	____	____
Earaches or drainage	____	____
Chronic sinus problems/ Rhinitis	____	____
Nose Bleeds	____	____
Mouth Sores	____	____
Bleeding Gums	____	____
Bad Breath/bad taste	____	____
Sore throat/voice change	____	____
Swollen glands in neck	____	____
Cardiovascular		
Heart trouble	____	____
Chest pain/angina pectoris	____	____
Palpitation	____	____
Shortness of breath with Walking or lying flat	____	____
Swelling of feet/ankles/ Hands	____	____
Respiratory		
Chronic/frequent coughs	____	____
Spitting up blood	____	____
Shortness of breath	____	____
Wheezing	____	____
Gastrointestinal		
Loss of appetite	____	____
Change in bowel Movements	____	____
Nausea or vomiting	____	____
Frequent diarrhea	____	____
Painful bowel movements Or constipation	____	____
Rectal bleeding/blood in stool	____	____
Abdominal pain	____	____
Genitourinary		
Frequent Urination	____	____
Burning or painful urination	____	____
Blood in urine	____	____
Change in force of strain When urinating	____	____
Incontinence or dribbling	____	____
Kidney stones	____	____
Sexual difficulty	____	____
Male testicle pain	____	____
Female pain with periods	____	____
Female irregular periods	____	____
Female vaginal discharge	____	____
Female # pregnancies	_____	
Female # miscarriages	_____	
Female date last pap smear	_____	
Musculoskeletal		
Joint pain	____	____
Joint stiffness/swelling	____	____
Weakness muscles/joints	____	____
Muscle pain/cramps	____	____
Back pain	____	____
Cold extremities	____	____
Difficulty walking	____	____
Integumentary (skin, breast)		
Rash or itching	____	____
Change in skin color	____	____
Change in hair or nails	____	____
Varicose veins	____	____
Breast pain	____	____
Breast lump	____	____
Breast discharge	____	____
Neurological		
Headaches	____	____
Light headed/dizzy	____	____
Convulsions/seizures	____	____
Numbness/tingling	____	____
Tremors	____	____
Paralysis	____	____
Head Injury	____	____
Psychiatric		
Memory loss	____	____
Nervousness	____	____
Depression	____	____
Insomnia	____	____
Suicidal thoughts	____	____
Endocrine		
Glandular/hormone issues	____	____
Excessive thirst/urination	____	____
Heat/cold intolerance	____	____
Skin becoming dryer	____	____
Change in hat/glove size	____	____

	Yes	No
Brittle/dry hair	____	____
Hematologic/Lymphatic		
Slow to heal after cuts	____	____
Bleeding/bruising tendency	___	____
Anemia	____	____
Phlebitis	____	____
Past transfusion	____	____
Enlarged Glands	____	____
Allergic/Immunologic: History of skin Reaction or adverse reaction to:		
Penicillin/other antibiotic(s)	___	____

	Yes	No
Morphine/Demerol/narcotics	___	___
Novocain/anesthetics	____	____
Aspirin/pain remedies	____	____
Tetanus/antitoxin/serums	____	____
Iodine/Merthiolate/antiseptic	____	____

Other Drug/Medications_____
_____
_____

Known food allergies _____
_____
_____

Environmental Allergies _____
_____
_____

Other_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in any medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ Date:_____

Patient, Parent or Guardian