Byers Chiropractic Center

139 N. St. Rt. 42, Waynesville, Ohio 45068
(513) 897-0997 (p) ~ (513) 897-1678 (f)

Patients Name: ____________________ Date:_________________

CONFIDENTIAL HEALTH HISTORY

Please place a check in the box next to the following items if you are currently experiencing these problems or have ever seen a doctor about these problems.

GENERAL

1 □ Fever
2 □ Chills
3 □ Night Sweats
4 □ Loss of Sleep
5 □ Fatigue
6 □ Nervousness
7 □ Weight Loss or Gain
8 □ Allergies
9 □ Bleeding Problem
10 □ Anemia
11 □ Diabetes
12 □ Cancer
13 □ Thyroid Disease/Goiter
14 □ Alcoholism
15 □ Drug Abuse

EYE, EAR, NOSE, THROAT

16 □ Poor Vision
17 □ Pain in Eye(s)
18 □ Deafness/Difficulty Hearing
19 □ Nosebleeds
20 □ Nose Problems
21 □ Sinus Trouble
22 □ Dental Problems
23 □ Hoarseness
24 □ Tonsillectomy

GASTROINTESTINAL

25 □ Poor Appetite
26 □ Poor Digestion
27 □ Difficulty Swallowing
28 □ Belching or Gas
29 □ Frequent Nausea
30 □ Vomiting
31 □ Vomiting Blood
32 □ Pain Over Abdomen
33 □ Ulcer
34 □ Black or Bloody Stools
35 □ Liver Problems
36 □ Gall Bladder Problems
37 □ Jaundice
38 □ Hernia
39 □ Diarrhea
40 □ Constipation
41 □ Hemorrhoids
42 □ Appendicitis

MEN ONLY

43 □ Testicular Swelling/Pain
44 □ Prostate Problems

RESPIRATORY

45 □ Difficulty Breathing
46 □ Chronic Cough
47 □ Spitting Phlegm
48 □ Spitting Blood
49 □ Wheezing/Asthma
50 □ Pneumonia
51 □ Tuberculosis

CARDIOVASCULAR

52 □ Irregular Heartbeat
53 □ High Blood Pressure
54 □ Pain Over Heart
55 □ Previous Heart Trouble
56 □ Ankle Swelling
57 □ Varicose Veins
58 □ Rheumatic Fever
59 □ Stroke

GENITOURINARY

60 □ Frequent Urination
61 □ Painful Urination
62 □ Blood in Urine
63 □ Kidney Disease
64 □ Urinary Infection
65 □ Inability to Control Urination
66 □ Difficulty Starting Urine Flow
67 □ Get Up ___ Times Per Night To Urinate
68 □ Venereal Infection
69 □ Sexual Difficulties
70 □ Breast Lump or Pain

SKIN

71 □ Itching
72 □ Bruising Easily
73 □ Change in Mole(s)
74 □ Skin Cancer

WOMEN ONLY

75 □ Painful Periods
76 □ Excessive Flow
77 □ Irregular Cycles
78 □ Vaginal Burning/Itching
79 □ Hot Flashes
80 □ Date Last Period Began _______________
81 □ Date of Last Pap test _______________
82 □ Hysterectomy

NEUROLOGIC

83 □ Weakness
84 □ Twitching
85 □ Tremors
86 □ Headache
87 □ Fainting
88 □ Dizziness
89 □ Convulsions
90 □ Epilepsy
91 □ Numbness/Tingling
92 □ Arm/Leg Pain
93 □ Mental Disorder

MUSCULOSKELETAL

94 □ Neck Stiffness/Pain
95 □ Pain Between Shoulders
96 □ Low Back Pain
97 □ Swollen Joints
98 □ Painful Joints
99 □ Muscle Aches/Soreness
100 □ Spinal Curvature
101 □ Arthritis

HABITS

102 □ Smoking ____ Packs Per Day
103 □ Drinking
104 □ Recreational Drug Use

EXERCISE

105 □ None
106 □ 1-2 Times per week
107 □ 3-5 Times per week
108 □ 6-7 Times per week

FAMILY HISTORY

Include information on your brothers, sisters, parents and grandparents. **NOT INCLUDE YOURSELF!**

109 □ Diabetes
110 □ Thyroid Disease/Goiter
111 □ Tuberculosis
112 □ Kidney Disease
113 □ High Blood Pressure
114 □ Heart Disease
115 □ Cancer
116 □ Muscle, Bone or Nerve Disease