SportsDocs Family Chiropractic Group, INC. **Dr. L. Jon Porman, DC, CCSP**

FAMILY HEALTH HISTORY

Name: _____ Chart:_____ Date:_____

The items below may relate to your current condition. Please *CHECK* the symptoms in the column if you are *CURRENTLY* troubled or if you have *EVER HAD* a particular symptom.

General
- ☐ Abnormal weight loss/ gain
- ☐ Alcoholism/ drug abuse
- ☐ Allergies
- ☐ Blood/ bleeding problems
- ☐ Breast lumps/ soreness
- ☐ Cancer
- ☐ Depression/ anxiety
- ☐ Diabetes
- ☐ Excessive thirst
- ☐ Fever/ chills without flu
- ☐ General fatigue
- ☐ Night sweats
- ☐ Poor sleep
- ☐ Thyroid disease/ goiter

Gastrointestinal
- ☐ Abdominal pain
- ☐ Appendicitis
- ☐ Belching/ gas
- ☐ Black/ bloody stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gallbladder problems
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Liver problems/ jaundice
- ☐ Frequent nausea/ vomiting
- ☐ Pain over abdomen
- ☐ Poor appetite
- ☐ Poor digestion
- ☐ Ulcer/ heartburn

Eye, Ear, Nose, and Throat
- ☐ Deafness/ difficulty hearing
- ☐ Dental problems
- ☐ Ear noises/ ringing
- ☐ Hoarseness
- ☐ Nosebleeds
- ☐ Nose problems
- ☐ Pain in/ behind eyes
- ☐ Sinus problems/ hay fever
- ☐ TMJ
- ☐ Tonsil problems
- ☐ Visual disturbances

Cardio-Respiratory
- ☐ Ankle swelling
- ☐ Asthma/ wheezing
- ☐ Chest pains
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Emphysema
- ☐ High blood pressure
- ☐ High cholesterol levels
- ☐ Irregular heartbeat
- ☐ Previous heart trouble
- ☐ Rheumatic Fever
- ☐ Spitting phlegm/ blood
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Varicose veins

Skin
- ☐ Bruising easily
- ☐ Change in mole(s)
- ☐ Itching / eczema/ rash
- ☐ Skin cancer

Genitourinary
- ☐ Blood in urine
- ☐ Difficulty starting flow
- ☐ Frequent urination
- ☐ Frequent night urination
- ☐ Inability to control flow
- ☐ Kidney disease/ stones
- ☐ Painful urination
- ☐ Sexual difficulties
- ☐ Urinary tract infection
- ☐ Venereal infection

Women Only
- ☐ Endometriosis
- ☐ Excessive flow
- ☐ Irregular cycles
- ☐ Hot flashes
- ☐ Painful periods
- ☐ PMS
- ☐ Pregnancy- # of births_____
- ☐ Vaginal burning/ itching
- ☐ Date last period began:_____
- ☐ Date of last PAP test:_____

Men Only
- ☐ Testicular swelling/ pain
- ☐ Prostate problems

Neurological
- ☐ Convulsions
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache
- ☐ Mental disorder
- ☐ Numbness/ tingling
- ☐ Twitching/ tremors/ epilepsy
- ☐ Weakness

Musculoskeletal
- ☐ Neck pain
- ☐ Pain between shoulders
- ☐ Low back pain
- ☐ Hip/ knee/ ankle/ foot pain
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Shoulder/ elbow/ wrist/ hand pain
- ☐ Scoliosis

Family History: (brothers, sisters, parents, grandparents only)
- ☐ Cancer
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Stroke
- ☐ Kidney disease
- ☐ Muscle, bone, nerve, disease
- ☐ Thyroid disease

Height_____

Weight_____

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FAMILY HEALTH HISTORY

Have you had any injuries in the past? Y◯ / N◯ Include auto/sports injuries, falls, and when they occurred:

_____

_____

_____

Have you had any surgeries or hospitalizations? Y◯/ N◯ Please list, with dates:

_____

_____

_____

Please describe any serious condition or disease you have or had (even if it is included on the check-off list), including when it occurred and the outcome of treatments received:

_____

_____

_____

I have completed this form to the best of my ability and discussed the information with Dr. Porman. I understand that Dr. Porman is relying upon this information to make treatment recommendations.

PATIENT SIGNATURE: _____DATE:_____

If the patient is not yet 18 years old, a parent or guardian must sign.

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