OSTEODOX
PATIENT HISTORY

PATIENT INFORMATION

PATIENT NAME	DATE
CHIEF COMPLAINT	
OTHER PROBLEMS	

PAST HISTORY	YES	NO
A. Disease of the heart, veins, or chest pains	☐	☐
B. High blood pressure	☐	☐
C. Diabetes, Sugar, Albumin, or Blood in Urine	☐	☐
D. Kidney stones, Kidney, Bladder, or Urinary Disease	☐	☐
E. Asthma, Bronchitis, Tuberculosis, or Lung Disease	☐	☐
F. Ulcers, Colitis, Disorders of the Stomach, Liver, or Gallbladder	☐	☐
G. Nervous Breakdown, Mental, or Nervous Disorder	☐	☐
H. Epilepsy, Unconsciousness, or Dizziness	☐	☐
I. Cancer, Tumor, or Polyp. If yes, where?	☐	☐
J. Arthritis, Rheumatic Fever, Gout, Paralysis, or Disease or Deformity of Bones	☐	☐
K. Disease of the Thyroid or Lymph Glands	☐	☐
L. Anemia, Leukemia, or other Blood Disease	☐	☐
M. Disease of the Prostate, Testes, Uterus, Ovaries, or Breast	☐	☐
N. Drugs: Heroin, Cocaine, Marijuana, Barbiturates, or other controlled substances	☐	☐
O. Do you smoke? If yes, how many packer per day?	☐	☐
P. Do you drink caffeinated beverages?	☐	☐
Q. Do you drink alcohol? If yes, how much daily?	☐	☐

FAMILY RECORD	AGE OF LIVING	AGE AT DEATH	MEDICAL PROBLEMS
FATHER			
MOTHER			
SISTERS			
BROTHERS			
PLEASE LIST ANY DRUG ALLERGIES			

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