Dolmat Chiropractic Clinic
Health History Form

Name _____ Date _____ _

Have you ever been diagnosed with, treated for or had indications of any of the following conditions?
If YES provide medical details at bottom of page.

Arthritis or rheumatism	yes	no
Asthma or other respiratory conditions	yes	no
Allergies	yes	no
Blood or circulatory problems	yes	no
Heart disease, angina	yes	no
High Blood Pressure *	yes	no
Heart attack	yes	no
Headaches or Migraines	yes	no
Cancer or tumor	yes	no
Epilepsy or seizures	yes	no
Disorders of spine, discs, joints, bones	yes	no
Colitis or intestinal problems	yes	no
Diabetes	yes	no
Diseases of eyes, ears, nose, throat	yes	no
AIDS or HIV	yes	no
Stroke	yes	no
lupus	yes	no
Gallbladder disease or gallstones	yes	no
Kidney disease or kidney stones	yes	no
Liver trouble	yes	no
Paralysis	yes	no
Thyroid problem or goiter	yes	no
Ulcers or stomach trouble	yes	no
Emotional or mental condition	yes	no
Do you smoke?	yes	no
Other	yes	no

* If "yes" indicate the following: Last reading _____