TRITON WELLNESS SOLUTIONS
& SoftWave Therapy

Patient Health History

Patient Name:____ **Date:**______________________

Medical Conditions: (Check all that apply to you, currently or in the past)

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Kidney
☐ Osteoarthritis	☐ Mental Disorders	☐ Skin Disorder	☐ Stroke
☐ Epilepsy	☐ Rheumatic Fever	☐ HIV positive	☐ Tuberculosis
☐ Thyroid	☐ High Blood Pressure/Hypertension		☐ Heart Disease

☐ Other ____

Surgeries: (Check all that apply to you)

☐ Appendectomy	☐ Cardiovascular procedure	☐ Cervical spine	☐ Hysterectomy
☐ Joint Replacement	☐ Prostate	☐ Lumbar spine	☐ Gall Bladder
☐ Knee	☐ Shoulder	☐ Thoracic spine	☐ Hernia
☐ Hip	☐ Female/Male Surgery	☐ Gastro-intestinal	☐ Rectal
☐ Tonsillectomy	☐ Sinus	☐ Carpal Tunnel	☐ Brain

Others ____

Allergies:

Food/Environmental ____

Medications ____

Social History: (Check all that apply to you)

Caffeine use:	☐ occasional	☐ often	☐ never
Drink Alcohol:	☐ occasional	☐ often	☐ never
Chew Tobacco:	☐ occasional	☐ often	☐ never
Cigarettes:	☐ <1 pack/day	☐ >1 pack/day	☐ never

Family History: (Circle all that apply)

Arthritis:	Mother	Father	Sister	Brother
Cancer:	Mother	Father	Sister	Brother
Diabetes:	Mother	Father	Sister	Brother
Heart Disease:	Mother	Father	Sister	Brother
Hypertension:	Mother	Father	Sister	Brother
Kidney:	Mother	Father	Sister	Brother
Stroke:	Mother	Father	Sister	Brother
Thyroid:	Mother	Father	Sister	Brother
Back Pain:	Mother	Father	Sister	Brother
Headaches:	Mother	Father	Sister	Brother

Other: __________________

Medications: List all medications you are currently taking. 1) ______________________________

2) ______________________________ **3)** ______________________________

4) ______________________________ **5)** ______________________________

6) ______________________________ **7)** ______________________________

8) ______________________________ **9)** ______________________________

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Review of Systems – (Check the box if you ***have had*** or ***are having*** trouble with any of the following, if no issues check n/a)

Cardiovascular	Past	Present	n/a	**Respiratory**	Past	Present	n/a	**Allergic/Immunologic**	Past	Present	n/a
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurysm				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Bronchitis				Cortisone Use			
Chest Pain				Cough/Cold/Flu				Medication			
High Cholesterol				Wheezing				Airborne Allergies			
Pacemaker				Pneumonia							
Jaw Pain								**Ear, Nose and Throat**	Past	Present	n/a
Irregular heartbeat				**Eyes**	Past	Present	n/a	Difficulty Swallowing			
Swelling of legs				Cataracts				Dizziness/Vertigo			
Left arm pain				Glaucoma				Hearing Loss			
				Double Vision				Ear Noises			
Genitourinary	Past	Present	n/a	Blurred Vision				Sore Throat			
Kidney Disease				Glasses				Nosebleeds			
Burning Urination								Bleeding Gums			
Frequent Urination				**Psychiatric**	Past	Present	n/a	Sinus Infections			
Blood in Urine				Mood Swings							
Kidney Stones				Depression				**Gastrointestinal**	Past	Present	n/a
Prostate Issues				Anxiety				Pancreatitis			
				Stress				Gallbladder Problems			
Neurologic	Past	Present	n/a					Bowel Problems			
Tingling				**Endocrine**	Past	Present	n/a	Constipation			
Numbness				Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures/Epilepsy				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Concussion				Goiter				Heartburn			
Severe Headaches								Colitis			
Pinched Nerves				**Hematologic**	Past	Present	n/a				
Parkinson's				Hepatitis				**Musculoskeletal**	Past	Present	n/a
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
Multiple Sclerosis				Bruising				Joint Stiffness			
				Bleeding				Muscle Weakness			
Constitutional	Past	Present	n/a	Fever, Chills				Osteoporosis			
Rheumatic Fever				Sweating				Broken Bones			
Weight Loss/Gain				Anemia				Joints Replaced			
Low Energy Level				Lymphoma				Spina Bifida			
Difficulty Sleeping				Slow Healing				Back Pain/Stiffness			
Poor Appetite								Neck Pain/Stiffness			

WOMEN: Are you pregnant? No ______ Yes_____ How many weeks?_______

SIGNATURE OF PROVIDER: _________________________________ **Date:** ___________________