TRITON WELLNESS SOLUTIONS
& SoftWave Therapy

Patient Health History

Patient Name:_____ **Date:**_____

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

Rheumatoid Arthritis	Cancer	Diabetes	Kidney
Osteoarthritis	Mental Health	Skin Disorder	Stroke
Epilepsy/Seizures	Rheumatic Fever	HIV	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	Vasectomy	Gastro-intestinal	Rectal
Tonsillectomy	Sinus	Carpal Tunnel	Brain

Others _____

Allergies: (Medications/Food/Environmental)_____

_____

Social History: (Check all that apply to you)

Caffeine use:	Currently use	Former use	Never used
Drink Alcohol:	Currently use	Former use	Never used
Chew Tobacco:	Currently use	Former use	Never used
Cigarettes:	Currently use	Former use	Never used

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)** _____

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Review of Systems – (Check the box if you ***have had*** or ***are having*** trouble with any of the following)

Cardiovascular	Past	Present
Poor Circulation		
Hypertension		
Aortic Aneurysm		
Heart Disease		
Heart Attack		
Chest Pain		
High Cholesterol		
Pacemaker		
Jaw Pain		
Irregular heartbeat		
Swelling of legs		
Left arm pain		
Genitourinary	Past	Present
Kidney Disease		
Burning Urination		
Frequent Urination		
Blood in Urine		
Kidney Stones		
Prostate Issues		
Neurologic	Past	Present
Tingling		
Numbness		
Stroke		
Seizures/Epilepsy		
Head Injury		
Brain Aneurysm		
Concussion		
Severe Headaches		
Pinched Nerves		
Parkinson's		
Carpal Tunnel		
Vertigo		
Multiple Sclerosis		
Constitutional	Past	Present
Rheumatic Fever		
Weight Loss/Gain		
Low Energy Level		
Difficulty Sleeping		
Poor Appetite		

Respiratory	Past	Present
Asthma		
Tuberculosis		
Short Breath		
Emphysema		
Bronchitis		
Cough/Cold/Flu		
Wheezing		
Pneumonia		
Eyes	Past	Present
Cataracts		
Glaucoma		
Double Vision		
Blurred Vision		
Glasses		
Psychiatric	Past	Present
Mood Swings		
Depression		
Anxiety		
Stress		
Endocrine	Past	Present
Thyroid		
Diabetes		
Hair Loss		
Menopausal		
Menstrual		
Goiter		
Hematologic	Past	Present
Hepatitis		
Blood Clots		
Cancer		
Bruising		
Bleeding		
Fever, Chills		
Sweating		
Anemia		
Lymphoma		
Slow Healing		

Allergic/Immunologic	Past	Present
Hives		
Immune Disorder		
HIV/AIDS		
Allergy Shots		
Cortisone Use		
Medication		
Airborne Allergies		
Ear, Nose and Throat	Past	Present
Difficulty Swallowing		
Dizziness/Vertigo		
Hearing Loss		
Ear Noises		
Sore Throat		
Nosebleeds		
Bleeding Gums		
Sinus Infections		
Gastrointestinal	Past	Present
Pancreatitis		
Gallbladder Problems		
Bowel Problems		
Constipation		
Liver Problems		
Ulcers		
Diarrhea		
Nausea/Vomiting		
Bloody Stools		
Heartburn		
Colitis		
Musculoskeletal	Past	Present
Gout		
Arthritis		
Joint Stiffness		
Muscle Weakness		
Osteoporosis		
Broken Bones		
Joints Replaced		
Spina Bifida		
Back Pain/Stiffness		
Neck Pain/Stiffness		

WOMEN: Are you pregnant? No _____ Yes_____ How many weeks?_____

Anything else you would like to talk about that was not covered above: _____