# HEALTH HISTORY

PATIENT NAME _____ BIRTHDATE ____/____/____ PATIENT # _____

To help us meet all your healthcare needs, please fill out **both sides** of this form completely in ink. This is a confidential record of your medical history and will be kept in this office.

Today's date _____
Place of birth _____
Highest level in school _____
Occupation _____
Previous occupations _____
Marital status _____
Hobbies _____
Exercise/recreation _____
Habits:
Smoking (type & amount per day) _____
If former smoker, date quit _____
Alcohol (type & amount per week) _____
Caffeine (type & amount per day) _____
Street drugs (type & amount per day) _____
Usual weight _____
Date of last dental exam _____
Please list all allergies (foods, drugs, environment)

When was your last physical exam? _____
Name of doctor _____ Phone _____
Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred: ☐ none

Please list all medicines you are currently taking (include nonprescription drugs): ☐ none

Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred): ☐ none

**Chief Complaints**
Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

**Past Medical History**
Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Measles | no | yes | Migraine headaches | no | yes | Hives or Eczema | no | yes |
| Mumps | no | yes | Tuberculosis | no | yes | AIDS or HIV+ | no | yes |
| Chickenpox | no | yes | Diabetes | no | yes | Infectious Mono | no | yes |
| Whooping Cough | no | yes | Cancer | no | yes | Bronchitis | no | yes |
| Scarlet Fever | no | yes | Polio | no | yes | Mitral Valve Prolapse | no | yes |
| Diphtheria | no | yes | Glaucoma | no | yes | Stroke | no | yes |
| Smallpox | no | yes | Hernia | no | yes | Hepatitis | no | yes |
| Pneumonia | no | yes | Blood or Plasma transfusions | no | yes | Ulcer | no | yes |
| Rheumatic Fever | no | yes | | | | Kidney Disease | no | yes |
| Heart Disease | no | yes | Back trouble | no | yes | Thyroid Disease | no | yes |
| Arthritis | no | yes | High or low blood pressure | no | yes | Bleeding tendency | no | yes |
| Venereal Disease | no | yes | | | | Any other disease (please list) | no | yes |
| Anemia | no | yes | Hemorrhoids | no | yes | | | |
| Bladder Infections | no | yes | Date of last chest x-ray | | | | | |
| Epilepsy | no | yes | Asthma | no | yes | | | |

**Family History**
Has any blood relative had any of the following: (Circle "no" or "yes", leave blank if uncertain)

| | | | Relationship | | | | Relationship |
|---|---|---|---|---|---|---|---|
| Cancer | no | yes | | Stroke | no | yes | |
| Tuberculosis | no | yes | | Epilepsy | no | yes | |
| Diabetes | no | yes | | Allergies | no | yes | |
| Heart Disease | no | yes | | Anemia | no | yes | |
| High blood pressure | no | yes | | Bleeding tendency | no | yes | |

**Family History (cont.)**
(Circle "no" or "yes", leave blank if uncertain)

| | | | Relationship | Present age, or age of death | If living, health (good, fair, poor) If deceased, cause of death |
|---|---|---|---|---|---|
| Asthma | no | yes | | Father | |
| Chronic lung disease | no | yes | | Mother | |
| Drug or alcohol problem | no | yes | | Siblings | |
| Mental Illness | no | yes | | | |
| Leukemia | no | yes | | | |
| Migraine headaches | no | yes | | | |
| Obesity | no | yes | | | |
| Thyroid Disease | no | yes | | Spouse | |
| Ulcer | no | yes | | Children | |
| Depression | no | yes | | | |
| High Cholesterol | no | yes | | | |
| Kidney Disease | no | yes | | | |
| Glaucoma | no | yes | | | |
| Gout | no | yes | | | |

**Do you have now or have you had within the past year:**
(Circle "no" or "yes", leave blank if uncertain)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Weakness or paralysis | no | yes | Bloody sputum | no | yes | Joint pain or stiffness | no | yes |
| Tire easily or weakness | no | yes | Wheezing | no | yes | Swollen joints | no | yes |
| Recent weight changes | no | yes | Chest pain or discomfort | no | yes | Muscle cramps or spasms | no | yes |
| Change in appetite | no | yes | Purple fingers or lips | no | yes | Sleeplessness | no | yes |
| Sensitivity to cold or heat | no | yes | Swelling of hands, feet or ankles | no | yes | Seizures | no | yes |
| Persistent fever | no | yes | Difficulty in breathing | no | yes | Depression | no | yes |
| Night sweats or hot flashes | no | yes | Palpitations or fluttering of the heart | no | yes | Memory loss | no | yes |
| Skin rash | no | yes | Leg cramps on walking or at night | no | yes | Poor coordination | no | yes |
| Skin trouble or changes | no | yes | Enlarged veins | no | yes | Dizziness or fainting spells | no | yes |
| Change in nails or hair | no | yes | Difficulty swallowing | no | yes | A living will or advance directive | no | yes |
| Headaches | no | yes | Heartburn | no | yes | **Men only:** | | |
| Easy bleeding or bruising | no | yes | Frequent belching | no | yes | Discharge from penis | no | yes |
| Double vision | no | yes | Abdominal cramping | no | yes | Pain or lump in testicles | no | yes |
| Blurred vision | no | yes | Nausea | no | yes | Impotence | no | yes |
| Eye pain | no | yes | Vomiting | no | yes | **Women only:** | | |
| Infected eyes | no | yes | Vomited or coughed up blood | no | yes | Age period began _____ | | |
| Do you wear glasses or contacts | no | yes | Chronic diarrhea | no | yes | How many days do periods last? _____ | | |
| When was your last eye exam_____ | | | Chronic constipation | no | yes | How many days between periods? _____ | | |
| Ringing in the ears | no | yes | Rectal bleeding | no | yes | Is the flow heavy? | no | yes |
| Discharge from ears | no | yes | Black tarry stools | no | yes | Do you bleed or spot between periods? | no | yes |
| Ear pain | no | yes | Dark urine | no | yes | Do you have pain or cramps? | no | yes |
| Decrease in hearing | no | yes | Yellow jaundice | no | yes | Date of last period? _____ | | |
| Frequent nosebleeds | no | yes | Frequent urination (day) | no | yes | Date of last pelvic exam? _____ | | |
| Frequent colds | no | yes | Frequent urination (night) | no | yes | Date of last mammogram? _____ | | |
| Sinus trouble | no | yes | Increase in thirst | no | yes | Any itching in vaginal area? | no | yes |
| Loss of smell | no | yes | Painful urination | no | yes | Pain with intercourse? | no | yes |
| Persistent hoarseness | no | yes | Leakage of urine | no | yes | Type of birth control used?_____ | | |
| Sore throat | no | yes | Difficulty in starting urine | no | yes | Number of pregnancies _____ | | |
| Sore tongue or gums | no | yes | Blood in urine | no | yes | Number of full term births _____ | | |
| Lump or discharge from breast | no | yes | Lack of sex drive | no | yes | Number of preterm births_____ | | |
| Chronic or frequent cough | no | yes | Hemorrhoids | no | yes | | | |
| Shortness of breath | no | yes | Backaches | no | yes | | | |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

X_____ _____
Signature of patient or parent if minor — Date

Physician's Comment

Physician's Signature _____

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