FAMILY/PERSONAL HEALTH HISTORY

All information is treated in confidence and will not be released without permission

Name_____ Birthdate_____ Today's Date_____ Phone_____

Family Record	YES	NO	FATHER	MOTHER	BROTHER	SISTER	SON	DAUGHTER
Alcoholism								
Allergies								
Anemia								
Arthritis								
Asthma								
Birth Defects								
Bleeding Tendencies								
Cancer, tumor								
Colitis								
Congenital Heart								
Diabetes								
Emphysema								
Epilepsy								
Glaucoma								
Goiter								
Hay Fever								
Heart Attack								
Heart Disease								
High Blood Pressure								
Kidney Disease								
Leukemia								
Liver Disease								
Mental Illness								
Migraine								
Nervous Breakdown								
Obesity								
Rheumatism								
Rheumatic Fever								
Sickle Cell								
Stomach Ulcer								
Stroke								
Suicide								
Tuberculosis								

FAMILY MEMBERS	AGE	GOOD HEALTH	FAIR HEALTH	POOR HEALTH		AGE OF DEATH
Father						
Mother						
Brother(s)						
Sister(s)						

Cause of Death:

Surgery	YES	NO	DATE
Tonsils			
Appendix			
Gall Bladder			
Stomach			
Kidney			
Colon			
Thyroid			
Hernia			
Breast			
Uterus			
Ovaries			
Prostate			
Other-if yes, what:			
Social			**DAILY AMOUNT**
Smoke			
Coffee			
Beer			
Hard Liquor			
Immunizations			
Pneumonia			
Tetanus			
Booster			
Measles			
Flu			
German Measles/Mumps			
Other			
X-RAYS			**DATE**
Mammogram			
Back			
Chest			
Colon	__	__	_____
Extremities	__	__	_____
Gall Bladder	__	__	_____
Kidney	__	__	_____
Stomach			
Other:			

NAME:_____

DATE: _____

STUDY OF SYSTEMS

CONDITIONS	YES	NO
GENERAL		
Fever		
Chills		
Bruise easily		
Swollen glands		
Loss of memory		
General weakness		
Aches/Pains		
HEAD		
Double Vision		
Light flashes		
Blurred vision		
Halos around lights		
Eye pain		
Ear pain		
Ear drainage		
Buzzing/ringing in ears		
Nose bleeds		
Sinus problems		
Difficulty swallowing		
Deafness		
Mouth/Tooth/Tongue Problems		
Persistent hoarseness		
Severe headaches		
Other:*		
SKIN		
Rash		
Changing moles		
Pigmentation		
Other:*		
HEART/CHEST/LUNGS		
Irregular heartbeat		
Shortness of breath		
Low exercise tolerance		
Heart flutters		
Chest pains		
Frequent coughs		
Coughing up blood		
Wheezing		
Night sweats		
Swollen Ankles		
Leg cramps		
Other:*		

*Explanation of 'Other':

CONDITIONS	YES	NO
NECK		
Stiffness		
Swelling		
Lumps		
Other:*		
GASTROINTESTINAL		
Poor appetite		
Indigestion/Heartburn		
Nausea		
Vomiting blood		
Abdominal pain or cramps		
Abdominal Tension		
Diarrhea		
Constipation		
Changes in bowel habits		
Rectum blood passage		
Black/tarry bowel movements		
Other:*		
KIDNEY		
Up nights to urinate		
Blood in urine		
Burning/pain when urinating		
Problem passing urine		
Trouble controlling urine		
Other:*		
NEUROMUSCULAR		
Leg or arm weakness		
Balance problems		
Dizziness		
Fainting spells		
Speech problems		
Other:*		
BONES/JOINTS		
Joint pain/swelling		
Muscle strength loss		
Muscle lump or swelling		
Lump on bone		
Pains in back		
Other:*		
ENDOCRINE		
Constant thirst		
Cold intolerance		
Heat intolerance		
Very sluggish/tired		
Jumpy/Nervous		

CONDITIONS	YES	NO
PSYCHOLOGICAL		
Is your life:		
Satisfactory		
Boring		
Demanding		
Unsatisfactory		
Is there worry over:		
Home life		
Marriage		
Job		
Children		
Money		
Do you:		
Often feel depressed		
Have irrational fears		
Feel upset		
Feel things often go wrong		
Feel shy		
Cry easily		
Feel inferior		
Have you:		
Attempted suicide		
Seriously considered suicide		
GENITALIA (MEN)		
Lump in testicles		
Penis discharge		
Breast lump		
Sore(s) on penis		
Erection difficulties		
Other:*		
GENITALIA (WOMEN)		
Breast lump(s)		
Nipple discharge		
Vaginal discharge		
Non-period bleeding/Spotting		
Hot flashes		
Pain w/ intercourse		
Possible pregnancy		
Change in periods		
Pain other than w/ periods		
Other:*		

*Explanation of 'Other'