HEALTH HISTORY

(Confidential)

Patient Name:_____ Today's Date_____

Age:_____Date of Birth:_____Date of last physical examination_____

What is your reason for visit?_____

SYMPTOMS: Check (√) symptoms you currently have or have had in the past year

GENERAL

- ❑ Chills
- ❑ Depression
- ❑ Dizziness
- ❑ Fainting
- ❑ Fever
- ❑ Forgetfulness
- ❑ Headache
- ❑ Loss of sleep
- ❑ Loss of weight
- ❑ Nervousness
- ❑ Numbness
- ❑ Sweats

MUSCLE /JOINT/BONE

Pain, weakness, or numbness in:

- ❑ Arms
- ❑ Back
- ❑ Feet
- ❑ Hands
- ❑ Hips
- ❑ Legs
- ❑ Neck
- ❑ Shoulders

GENITO-URINARY

- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Lack of Bladder Control
- ❑ Painful urination)

GASTROINTESTINAL

- ❑ Appetite poor
- ❑ Bloating
- ❑ Bowel Changes
- ❑ Constipation
- ❑ Diarrhea
- ❑ Excessive hunger
- ❑ Excessive thirst
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Nausea
- ❑ Rectal bleeding
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Vomiting blood

CARDIOVASCULAR

- ❑ Chest pain
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Low blood pressure
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Swelling of angles
- ❑ Varicose veins

EYE, EAR, NOSE, THROAT

- ❑ Bleeding gums
- ❑ Blurred vision
- ❑ Crossed eyes
- ❑ Difficulty swallowing
- ❑ Double vision
- ❑ Earache
- ❑ Ear discharge
- ❑ Hay fever
- ❑ Hoarseness
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Persistent cough
- ❑ Ringing in ears
- ❑ Sinus problems
- ❑ Vision – Flashes
- ❑ Vision – Halos

SKIN

- ❑ Bruise easily
- ❑ Hives
- ❑ Itching
- ❑ Change in moles
- ❑ Rash
- ❑ Scars
- ❑ Sore that won't heal

MEN ONLY

- ❑ Breast lump
- ❑ Erection difficulties
- ❑ Lump in testicles
- ❑ Penile discharge
- ❑ Sore on penis
- ❑ Other

WOMEN ONLY

- ❑ Abnormal Pap smear
- ❑ Bleeding between periods
- ❑ Breast lump
- ❑ Extreme menstrual pain
- ❑ Hot flashes
- ❑ Nipple discharge
- ❑ Painful intercourse
- ❑ Vaginal discharge
- ❑ Other

Date of last menstrual period_____

Date of last Pap Smear_____

Have you had a mammogram?_____

Are you pregnant?_____

Number of children:_____

CONDITIONS: Check (√) conditions you have had in the past.

- ❑ AIDS
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding disorder
- ❑ Breast lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical dependency
- ❑ Chicken pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herpes
- ❑ High Cholesterol
- ❑ HIV positive
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Measles
- ❑ Migraine headaches
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate problem
- ❑ Psychiatric care
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Stroke
- ❑ Suicide attempt
- ❑ Thyroid problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Typhoid fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal disease

MEDICATIONS (List medications you are taking. If you have a prepared list, please copy and bring with you)	**ALLERGIES** (To medications or substances):
PHARMACY NAME:	**PHARMACY PHONE:**

All information is strictly confidential

Family History: Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (√) if your blood relatives had any of the following: Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Stroke	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

Hospitalizations:

Year	Hospital	Reason for Hospitalization

Have you ever had a blood transfusion? ❑ Yes ❑ No

If yes, please give approximate dates:_____

Serious Illnesses/Injuries	Date	Outcome

Pregnancy History

Year of birth	Sex	Any Complications?

Habits: Check (√) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Marijuana	
	Other	

Occupational Concerns: Check (√) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other:
	Your occupation:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever had a change in health.

_____ _____

Signature of Patient, Parent, Guardian, or Personal representative — Date

_____ _____

Print name of Patient, Parent, Guardian, or Personal representative — Relationship to Patient

_____ _____

Reviewed By — Date