HEALTH INFORMATION SHEET

The following information is important to your health. Please take the time to accurately fill out this form

NAME_____ DATE OF BIRTH_____ TODAY'S DATE _____
Weight:_____ Height:_____
Reason for Today's Visit:_____

Past Medical Information: (Check Yes or No)

Diabetes	Yes__ No__	Heart Attack	Yes__ No__	Stroke	Yes__ No__
Heart Failure	Yes__ No__	Heart Murmur	Yes__ No__	Heart Valve ds	Yes__ No__
High Blood Pres	Yes__ No__	Asthma	Yes__ No__	Bronchitis	Yes__ No__
Peptic Ulcer	Yes__ No__	Hepatitis A/B/C	Yes__ No__	Glaucoma	Yes__ No__
Skin Cancer	Yes__ No__	Bleeding ds	Yes__ No__	Immune ds	Yes__ No__
Head Trauma	Yes__ No__	HIV/AIDS	Yes__ No__	Blood Transfusion	Yes__ No__
Seizures	Yes__ No__	Depression	Yes__ No__	Thyroid ds	Yes__ No__

Other (Specify) _____

Surgeries:(Specify all operations/dates):_____

List ALL MEDICATIONS:_____

Pharmacy Name:_____Address/City:_____Phone :_____

ALLERGIES: Medications_____ Reactions _____

Family History:

Diabetes	Yes__ No__	Heart Disease	Yes__ No__	Hypertension	Yes__ No__
Bleeding disorder	Yes__ No__	Cancer	Yes__ No__	Hearing Loss	Yes__ No__

Social History:

Occupation _____		Noise Exposure	Yes__ No__	Chemical Exposure	Yes__ No__
Married	Yes__ No__	Children	Yes__ No__	Ages_____	
Smoking	Yes__ No__	How Much _____		How Long_____	
Alcohol	Yes__ No__	How Much _____		How Long_____	
IV Drug Use	Yes__ No__	How Much _____		How Long_____	

AIDS/HIV Risks _____

Review of Symptoms:

General:	Change in appetite Yes__No__	Fever/Chills Yes__No__	Fatigue Yes__No__
	Headache Yes__No__	Lightheadedness Yes__No__	Night sweats Yes__No__
	Sleep disturbance Yes__No__	Weight gain Yes__No__	Weight loss Yes__No__
Allergy:	Congestion Yes__No__	Cough Yes__No__	Hives/Rash Yes__No__
	Itching Yes__No__	Sneezing Yes__No__	Watery eyes Yes__No__
Ophthalmologic:	Glasses/Contacts Yes__No__	Blurred vision Yes__No__	Diminished visual acuity Yes__No__
	Dry eye Yes__No__	Itching eye Yes__No__	Red eye Yes__No__
Respiratory:	Breathing problem Yes__ No__	Chest pain Yes__No__	Coughing up blood Yes__No__
	Pain with inspiration Yes__ No__	Shortness of breath at rest Yes__No__	
	Sputum production Yes__ No__	Wheezing Yes__No__	
Cardiovascular:	Chest pain at rest Yes__ No__	Chest pain with exertion Yes__No__	
	Difficulty laying flat Yes__ No__	Dizziness Yes__No__	Fluid retention in the legs Yes__No__
	Irregular heartbeat Yes__ No__	Palpitations Yes__No__	Weakness Yes__No__
Neurologic:	Balance difficulty Yes__ No__	Dizziness Yes__No__	Gait abnormality Yes__No__
	Headache Yes__ No__	Loss of strength Yes__No__	Memory loss Yes__No__
	Seizures Yes__ No__	Tingling/Numbness Yes__No__	Transient loss of vision Yes__No__

I attest that the above information is true and correct to the best of my belief

X_____ X_____ X_____ X_____
Patient's Signature Date
X_____ X_____ X_____ X_____
Physician/ARNP's Signature Date