

# HEALTH HISTORY

## Confidential

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ 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, numbness in:

- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ 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 ankles
- ☐ 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
- ☐ Penis 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 or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ 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 currently taking.

### ALLERGIES To medications or substances

_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
Pharmacy Name _____	Phone _____

**All information is strictly confidential**

**FAMILY HISTORY** Fill in health information about your immediate family.

FAMILY HISTORY						
Fill in health information about your immediate family.						
Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following:	
					Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
					High Blood Pressure	
Sisters					Kidney Disease	
					Tuberculosis	
					Other	

## HOSPITALIZATIONS

[illegible]

### PREGNANCY HISTORY

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

If yes, please give approximate dates.

**HEALTH HABITS** Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

### SERIOUS ILLNESS/INJURIES

## DATE \_\_\_\_\_

## OUTCOME

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME	Other
			<b>OCCUPATIONAL CONCERNS</b>
			Check (✓) if your work exposes you to the following:
			Stress
			Hazardous Substances
			Heavy Lifting
			Other
			Your occupation:

## 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 have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date \_\_\_\_\_

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Reviewed By

Date \_\_\_\_\_