HEALTH HISTORY

CONFIDENTIAL

Patient Name ______________________ Date ____________

Age ________ Birthdate ____________ Date of Last Physical Examination ____________

What is your reason for visit? ______________________

SYMPTOMS Encircle the 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
- Sweats

MUSCLE/JOINT/BONE

Pain, Weak, Numbness in

Arms	Hips
Back	Legs
Feet	Neck
Hands	Shoulders

GENITO-URINARY
- Blood in Urine
- Frequent Urination
- Lack of Bladder Control
- Painful Urination

GASTROINTESTINAL
- Poor Appetite
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- 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
- Blurred Vision
- Crossed Eye
- Double Vision
- Vision Flashes
- Vision - Halos
- Ear Pain
- Ear Discharge
- Ringing in Ears
- Loss of Hearing
- Difficulty Swallowing
- Hoarseness
- Persistent Cough
- Sinus Problem
- Nose Bleeds
- Hay Fever

SKIN
- Bruise
- Hives
- Itching
- Change in Moles
- Rash
- Scars
- Sore that won't heal

MEN ONLY
- Breast lump
- Erection Difficulties
- Lump in Testicles
- Penis Discharge
- Sore in Penis
- Other

WOMEN ONLY
- Abnormal pap Smear
- Bleeding between periods
- Breast Lump
- Extreme mentrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other

Date of last mentrual period ____________

Date of last Pap Smear ____________

Date of last mammogram ____________

Are you pregnant? ________

Number of children ________

CONDITIONS Encircle the conditions you have or have had in the past.

AIDS	Chemical Dependency	High Cholesterol	Prostate Problems
Alcoholism	Chicken Pox	HIV Positive	Psychiatric care
Anemia	Diabetes	Kidney Disease	Rheumatic Fever
Anorexia	Emphysema	Liver Disease	Scaret Fever
Appendicitis	Epilepsy	Measles	Stroke
Arthritis	Glaucoma	Migraine Headaches	Suicide Attempt
Asthma	Goiter	Miscarriage	Thyroid Problems
Bleeding disorders	Gonorrhea	Mononucleosis	Tonsillitis
Breast Lump	Gout	Multiple Sclerosis	Tuberculosis
Bronchitis	Heart Disease	Mumps	Thyphoid Fever
Bulimia	Hepatitis	Pacemaker	Ulcers
Cancer	Hernia	Pneumonia	Vaginal infections
Cataracts	Herpes	Polio	Venereal disease

MEDICATIONS List medications you are currrently taking.	**ALLERGIES** To medications or substances
Pharmacy Name: 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	Mark (X) if, your blood relatives had any of the following:	Disease	Relation to you
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease	
Sisters						HighBlood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

HOSPITALIZATION

Year	Hospital	Reason for Hospitalization and Outcome

PREGNANCY HISTORY

Year	Sex	Complications if any

Health Habits Encircle the substances you use & describe how much you use

Caffeine	
Tobacco	
Street Drugs	
Other	

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

If yes, please give approximate dates. ____________________

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

OCCUPATIONAL CONCERNS

Encircle if your work exposes you to 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 ____________________