HEALTH HISTORY

(Confidential)

Patient Name: _____ Today's Date: _____

Age: _____ Birthdate: _____ Date of last physical examination: _____

What is 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 rate
___ Swelling of ankles
___ Varicose veins

EYE,EAR,NOSE,THROAT
___ Bleeding gums
___ Blurred vision
___ Crossed eyes
___ Difficulty swallowing
___ Double vision
___ Earache
___ Ear discharge
___ Hayfever
___ 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 discharge
___ 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 currently have or have had in the past year

___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 Scelerosis
___ Mumps
___ Pacemaker
___ Pneumonia
___ Polio
___ Prostate Problem
___ Psychiatric Care
___ Rheumatic Fever
___ Scarlet Fever
___ Stroke
___ Suicide Attempt
___ Thyroid Problems
___ Tonsilitis
___ Tuberculosis
___ Typhoid Fever
___ Ulcers
___ Vaginal Infections
___ Veneral 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

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if your blood relatives had any of the following Diseases	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

PREGNANCY HISTORY

----Year of ----- Birth	Death	Complications if any

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

	Caffeine	
	Tobacco	
	Drugs	
	Other	

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

If yes, please give approximate date _____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

OCCUPATIONAL CONCERNS

Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your Occupation :

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature **Date**

_____ _____

Reviewed By **Date**