HEALTH HISTORY

Confidential

Patient Name _____ Birthdate_____ Age_____ Today's Date_____

Date of last physical examination _____ Reason for Visit: _____ Primary Care Provider: _____

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

Allergy/ Immunologic
- ☐ Increased susceptibility to infection
- ☐ Frequent sneezing

Cardiovascular
- ☐ Chest Pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid Heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

Constitutional
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Loss of Sleep
- ☐ Nervousness
- ☐ Numbness
- ☐ Weakness
- ☐ Weight gain- Amount: _____
- ☐ Weight loss- Amount:_____

Ears, Nose & Throat
- ☐ Difficulty swallowing
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds

Ears, Nose& Throat Cont.
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems

Endocrine
- ☐ Cold intolerance
- ☐ Diabetes
- ☐ Dry skin
- ☐ Excessive sweating
- ☐ Excessive urination
- ☐ Heat intolerance
- ☐ Hyperthyroid
- ☐ Hypothyroid

Eyes
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Double vision
- ☐ Dryness
- ☐ Itching eyes
- ☐ Loss of vision
- ☐ Vision- Flashes
- ☐ Vision- Halos

Gastrointestinal
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel change
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding

Gastrointestinal Cont.
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Genito- Urinary
- ☐ Blood in urine
- ☐ Difficult urination
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Pain or burning on urination
- ☐ Prostate trouble

Hematologic / Lymphatic
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Swollen glands
- ☐ Tender glands
- ☐ Transfusion When:_____

Men Only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other:_____

Muscle/ Joint / Bone Pain, Weakness, Numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips

Muscle/ Joint / Bone Pain, Weakness, Numbness in Cont.:
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

Neurological System
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache
- ☐ Loss of consciousness
- ☐ Memory loss
- ☐ Muscle spasm
- ☐ Night sweats

Psychiatric
- ☐ Agitation
- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Easily losing temper

Respiratory
- ☐ Cough
- ☐ Coughing of blood
- ☐ Difficulty in breathing at night
- ☐ Shortness of breath
- ☐ Swollen legs or feet
- ☐ Wheezing (asthma)

Skin
- ☐ Bruise easily
- ☐ Change in moles
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars
- ☐ Skin that wont heal

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 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 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

Family History

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

Medications

List medications you are currently taking.

_____

_____

_____

_____

_____

_____

Pharmacy Name_____

Phone _____

Allergies

List allergies you currently have.

_____

_____

Pregnancies

Year of Birth	Sex of Birth	Complications If any

Previous Operations

Year	Hospital	Operation

Health Habits

Check (✓) which you use and how much.

	Caffeine	
	Tobacco	
	Street Drugs	
	Alcohol	

Occupational

Check(✓) if your work exposes you to:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

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 — Date

_____ _____

Viewed By — Date