

# HEALTH HISTORY

(Confidential)

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	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	MEN only
<input type="checkbox"/> Chills	<input type="checkbox"/> Appetite poor	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Breast lump
<input type="checkbox"/> Depression	<input type="checkbox"/> Bloating	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Erection difficulties
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Bowel changes	<input type="checkbox"/> Crossed eyes	<input type="checkbox"/> Lump in testicles
<input type="checkbox"/> Fainting	<input type="checkbox"/> Constipation	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Penis discharge
<input type="checkbox"/> Fever	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Double vision	<input type="checkbox"/> Sore on penis
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Earache	<input type="checkbox"/> Other _____
<input type="checkbox"/> Headache	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Ear discharge	
<input type="checkbox"/> Loss of sleep	<input type="checkbox"/> Gas	<input type="checkbox"/> Hay fever	<b>WOMEN only</b>
<input type="checkbox"/> Loss of weight	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Abnormal Pap Smear
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Bleeding between periods
<input type="checkbox"/> Numbness	<input type="checkbox"/> Nausea	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Breast lump
<input type="checkbox"/> Sweats	<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Extreme menstrual pain
	<input type="checkbox"/> Stomach pain	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Hot flashes
<b>MUSCLE/JOINT/BONE</b>	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Nipple discharge
Pain, weakness, numbness in:	<input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Vision - Flashes	<input type="checkbox"/> Painful intercourse
<input type="checkbox"/> Arms		<input type="checkbox"/> Vision - Halos	<input type="checkbox"/> Vaginal discharge
<input type="checkbox"/> Back	<b>CARDIOVASCULAR</b>		<input type="checkbox"/> Other _____
<input type="checkbox"/> Feet	<input type="checkbox"/> Chest pain	<b>SKIN</b>	Date of last menstrual period _____
<input type="checkbox"/> Hands	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Bruise easily	Date of last Pap Smear _____
	<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Hives	Have you had a mammogram? _____
<b>GENITO-URINARY</b>	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Itching	Are you pregnant? _____
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Change in moles	Number of children _____
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Rapid heart beat	<input type="checkbox"/> Rash	
<input type="checkbox"/> Lack of bladder control	<input type="checkbox"/> Swelling of ankles	<input type="checkbox"/> Scars	
<input type="checkbox"/> Painful urination	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Sore that won't heal	

## CONDITIONS Check (✓) conditions you have or have had in the past.

<input type="checkbox"/> AIDS	<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Prostate Problem
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Measles	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Asthma	<input type="checkbox"/> Goiter	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mumps	<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hernia	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Vaginal Infections
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Herpes	<input type="checkbox"/> Polio	<input type="checkbox"/> 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 family.

Relation	Age	State of health	Age at death	Cause of death	Check if a relative had any of the following.	
					Disease	Relationship to you
FATHER					Arthritis, Gout	
MOTHER					Asthma, Hay Fever	
BROTHERS					Cancer	
					Diabetes	
					Heart Disease, stroke	
SISTERS					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					other	

**Do you see any specialists? (heart, OB/Gyn, etc.) Please list names & specialties.**

Date of last Mammogram \_\_\_\_\_ Date of last PSA blood test/prostate exam \_\_\_\_\_

HOSPITALIZATIONS / SURGERIES			PREGNANCY HISTORY		
Year	Hospital	Reason for hospitalization/surgery	Year of birth	Sex of birth	Complications (if any)

**Have you had a hysterectomy?**  NO  Partial? Or Total?

**Have you ever had a blood transfusion?**  Yes  No **HEALTH HABITS** Check the ones you use & describe how much you use.

If yes, give approximate date/s \_\_\_\_\_

Serious illness/injury	Date	Outcome	Caffeine
			Tobacco
			Drugs
			Other

**OCCUPATIONAL CONCERNS**

Check if your work exposes you to any of the following:

	Stress
	Hazardous substances
	Heavy lifting
	Other

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/her staff responsible for any errors or omissions that I have made in the completion of this form.

signature \_\_\_\_\_

date \_\_\_\_\_

Your occupation: \_\_\_\_\_