

HEALTH HISTORY

Name: _____ Birth date: _____

Today's Date: _____ Date of last physical examination: _____

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

<p>GENERAL</p> <input type="checkbox"/> Chills <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Loss of weight <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<p>RESPIRATORY</p> <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Decrease in exercise capacity	<p>SKIN</p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	<p>ALLERGIES</p> <input type="checkbox"/> Asthma <input type="checkbox"/> Hayfever or allergic rhinitis
<p>EYE, EAR, NOSE, THROAT</p> <input type="checkbox"/> Bleeding Gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems	<p>GASTROINTESTINAL</p> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation or diarrhea <input type="checkbox"/> Gas <input type="checkbox"/> Heartburn or indigestion <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Nausea or vomiting	<p>NEUROLOGICAL</p> <input type="checkbox"/> Dizziness or lightheadedness <input type="checkbox"/> Weakness <input type="checkbox"/> Fainting <input type="checkbox"/> Seizures	<p>WOMEN only</p> <input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge
<p>CARDIOVASCULAR</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling in ankles	<p>GENITO-URINARY</p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urinating <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful Urination	<p>PSYCHIATRIC</p> <input type="checkbox"/> Depression <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Nervousness <input type="checkbox"/> Stress <input type="checkbox"/> Trouble concentrating	<p>Date of last menstrual period _____</p> <p>Date of last pap smear _____</p> <p>Have you had a mammogram _____</p> <p>Are you pregnant? _____</p> <p>Number of children _____</p>
<p>MUSCLE/JOINT/BONE</p> <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<p>ENDOCRINE</p> <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Thyroid disease	<p>HEMATOLOGICAL</p> <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding disorder	<p>CARDIOVASCULAR</p> <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge

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

<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis	<input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts <input type="checkbox"/> Chemical dependency <input type="checkbox"/> Chicken pox <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy	<input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes	<input type="checkbox"/> HIV positive <input type="checkbox"/> Kidney disease <input type="checkbox"/> Liver disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraines <input type="checkbox"/> Miscarriages <input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio <input type="checkbox"/> Prostate problem <input type="checkbox"/> Psychiatric care <input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Scarlet fever <input type="checkbox"/> Stroke <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Venereal disease
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Please complete the back of this form also

PAST MEDICAL HISTORY: List surgeries you have had and the year.	
1.	2.
3.	4.

MEDICATIONS: List medications you are currently taking.		ALLERGIES: To medications or substances.
1.	8.	
2.	9.	
3.	10.	
4.	11.	
5.	12.	
6.	13.	
7.	14.	
Pharmacy Name:		Phone:

Fill in health information about your family				
	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Pregnancy History:

Year of Birth	Sex of Birth	Delivery Type	Complications if any

SOCIAL HISTORY:

Check (✓) the substance you use and describe how much you use.	
	Caffeine
	Tobacco
	Alcohol
	Other

FAMILY HISTORY:

List any illnesses that run in your family.	
1.	5.
2.	6.
3.	7.
4.	8.

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 may have made in the completion of this form.

Signature

Date

Physician Signature

Date Reviewed