DOROTHY COHEN SERNA, MD, PA
KELLY M. ENGLUND, MD

HEALTH HISTORY FORM

(Confidential)

Patient Name _____ Today's Date _____
Age ____ Birthdate _____ Date of last physical exam _____ Height _____Weight _____
What is your reason for visit?_____

Symptoms: (Check symptoms you currently have or have had in the past year)

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Sweats
- ☐ Fortgetfulness
- ☐ Numbness
- ☐ Difficulty sleeping
- ☐ Weight loss
- ☐ Weight gain
- ☐ Taken diet drugs
- ☐ Excessive thirst

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

PULMONARY
- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Cough with blood
- ☐ Wheezing

GASTROINTESTINAL
- ☐ Poor appetite
- ☐ Bloating
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting with blood
- ☐ Stomach pain
- ☐ Indigestion
- ☐ Rectal bleeding
- ☐ Hemorrhoids

URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred or double vision
- ☐ Difficulty swallowing
- ☐ Earache or drainage
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Ringing in ears
- ☐ Sinus problems

SKIN
- ☐ Easy bruising
- ☐ Rash
- ☐ Itching
- ☐ Sores that won't heal
- ☐ Change in moles
- ☐ Hives
- ☐ Severe sunburns
- ☐ Scars

MUSCLE / JOINTS
- ☐ Pain, numbness, weakness in:
  - ☐ back
  - ☐ neck
  - ☐ shoulders
  - ☐ arms
  - ☐ hands
  - ☐ hips
  - ☐ legs

MEN ONLY
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Discharge from penis
- ☐ Sore on penis
- ☐ Other

WOMEN ONLY
- ☐ Abnormal pap smear, If yes, date _____
- ☐ Bleeding between periods
- ☐ Bleeding after menopause
- ☐ Breast lump
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Extreme pain with menses
- ☐ Vaginal discharge
- ☐ Other _____

Date of:
Last menstrual period _____
Last pap smear _____
Last mammogram _____

Are you pregnant? ☐ Y ☐ N
Number of children: _____
Number of pregnancies: _____

OTHER
- ☐ _____
- ☐ _____

Conditions: (Check conditions you currently have or have had in the past)

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Cancer, if yes describe
  When: _____
  Type: _____
  Treatment: _____
- ☐ Cataracts
- ☐ COPD
- ☐ Chemical dependency
- ☐ Diabetes
- ☐ Eating disorder
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart attack
- ☐ Heart failure
- ☐ Other heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraine headaches
- ☐ Miscarriage
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Prostate problem
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Sexualy transmitted diseases
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis (or exposure)
- ☐ Ulcers
- ☐ Colitis
- ☐ Blood clot in leg
- ☐ **Other** _____

MEDICATIONS: Please fill out the separate MEDICATION PROFILE as accurately as possible!

ALLERGIES:

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Patient's Name:

FAMILY HISTORY

Relation	Age	State of Health	Health problems (if deceased, age, and cause)
Mother			
Father			
Brothers			
Sisters			

Have any of your blood relatives had any of the following: (Check\ and list relationship to you)

- Cancer (type:_____)
- Diabetes
- Heart attack
- Heart Disease
- Stroke
- High blood pressure
- Kidney disease
- Tuberculosis
- Arthritis or gout
- Asthma or hay fever
- Chemical dependency

HEALTH HABITS

	How much per day or How many yrs?	
Tobacco ❒ Now ❒ Quit		
Alcohol ❒ Now ❒ Past		
Drugs ❒ Now ❒ Past		
Other substances		
Exercise Type?		

Immunizations

Date of last Tetanus? _____
Date of last Flu shot? _____
Pneumonia Vaccine? _____
Have you ever had:
Shingles Vaccine? Y N
Hepatitis Vaccine? Y N
Other?_____

Describe Diet:

Hospitalizations

Year	Hospital	Reason for hospitalization and outcome

Serious illness / injuries / surgeries	Date	Outcome

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

Signature of patient _____ Date _____

Reviewed By _____ Date _____