Health History Form

North Cypress Internal Medicine & Wellness

(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

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
- ❒ Bloatting
- ❒ Change in bowel habits
- ❒ Constipation
- ❒ Diarrhea
- ❒ Excessive hunger
- ❒ Excessive thirst
- ❒ 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
- ❒ Breast lump
- ❒ Extreme pain with menses
- ❒ Hot flashes
- ❒ Nipple discharge
- ❒ Painful intercourse
- ❒ Vaginal discharge
- ❒ Other _____

Date of:

Last menstrual period _____

Last pap smear _____

Last mammogram _____

Are you pregnant? ❒ Y ❒ N

Number of children: _____

Number of pregnancies: _____

Complications of pregnancy in past: _____

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
- ❒ Vaginal infections
- ❒ Blood clot in leg
- ❒ Other

Medications: (list medications you are currently taking)

Pharmacy name:_____

Pharmacy phone #:_____

_____

_____

_____

_____

_____

ALLERGIES (TO MEDICATIONS OR SUBSTANCES):