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:

Patient's Name:

FAMILY HISTORY

Relation	Age	State of Health	Health problems (if deceased, age, and cause)	Have any of your blood relatives had any of the following: (Check\ and list relationship to you)
Mother				Cancer (type:_____)
Father				Diabetes
Brothers				Heart attack
				Heart Disease
				Stroke
				High blood pressure
Sisters				Kidney disease
				Tuberculosis
				Arthritis or gout
				Asthma or hay fever
				Chemical dependency

HEALTH HABITS		How much per day or How many yrs?		Immunizations
Tobacco	❒ Now ❒ Quit			Date of last Tetanus? _____
Alcohol	❒ Now ❒ Past			Date of last Flu shot? _____
Drugs	❒ Now ❒ Past			Pneumonia Vaccine? _____
Other substances				Have you ever had:
Exercise Type?				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 _____