HEALTH HISTORY

(CONFIDENTIAL)

Patients Name: _____

Reason for Visit: _____

Date of last Physical Exam: _____

SYMPTOMS: Check any symptoms you currently have or have had in the past:

General
- ☐Chills
- ☐Depression
- ☐Dizziness
- ☐Fainting
- ☐Fever
- ☐Forgetfulness
- ☐Headaches
- ☐Loss of Sleep
- ☐Loss of weight
- ☐Nervousness
- ☐Numbness
- ☐Sweats

Muscle/Joint/Bone
(pain, weakness, numbness)
- ☐Arms ☐Hips
- ☐Back ☐Legs
- ☐Feet ☐Neck
- ☐Hands ☐Shoulders

Genito-Urinary
- ☐Blood in Urine
- ☐Frequent Urination
- ☐No bladder control
- ☐Painful urination

Gastrointestinal
- ☐Appetite poor
- ☐Bloating
- ☐Bowel Changes
- ☐Constipation
- ☐Diarrhea
- ☐Excessive hunger
- ☐Excessive thirst
- ☐Gas
- ☐Hemorrhoids
- ☐Indigestion
- ☐Nausea
- ☐Rectal bleeding
- ☐Stomach pain
- ☐Vomiting
- ☐Vomiting blood

Cardiovascular
- ☐Chest pain
- ☐High blood pressure
- ☐Irregular heartbeat
- ☐Low blood pressure
- ☐Poor circulation
- ☐Rapid heart beat
- ☐Swelling of ankles
- ☐Varicose Veins

Eye/Ear/Nose/Throat
- ☐Bleeding gums
- ☐Blurred vision
- ☐Crossed eyes
- ☐Difficulty swallowing
- ☐Double vision
- ☐Earache
- ☐Ear discharge
- ☐Hay Fever
- ☐Hoarseness
- ☐Loss of hearing
- ☐Nosebleeds
- ☐Persistent cough
- ☐Ringing in ears
- ☐Sinus problems
- ☐Vision flashes/halos

Skin
- ☐Bruise easily
- ☐Hives
- ☐Itching
- ☐Change in moles
- ☐Rash
- ☐Scars
- ☐Sore(s) that won't heal

Men Only
- ☐Breast lump
- ☐Erection diff.
- ☐Lump in testicles
- ☐Penis discharge
- ☐Sore on penis
- ☐Other: _____

_____

Women Only
- ☐Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐Breast Lump
- ☐Extreme menstrual pain
- ☐Vaginal discharge
- ☐Hot flashes
- ☐Nipple discharge
- ☐Painful intercourse
- ☐Other: _____

_____

Date of last period:

_____

Date of last pap smear:

_____

Date of last mammogram:

_____

CONDITIONS: Check any conditions you have or have had in the past:

- ☐AIDS
- ☐Alcoholism
- ☐Anemia
- ☐Anorexia
- ☐Appendicitis
- ☐Arthritis
- ☐Asthma
- ☐Bleeding Disorders
- ☐Breast Lump
- ☐Bronchitis
- ☐Bulimia
- ☐Cancer
- ☐Cataracts
- ☐Chemical dependency
- ☐Chicken Pox
- ☐Diabetes
- ☐Emphysema
- ☐Epilepsy
- ☐Glaucoma
- ☐Goiter
- ☐Gonorrhea
- ☐Gout
- ☐Heart Disease
- ☐Hepatitis
- ☐Hernia
- ☐Herpes
- ☐High Cholesterol
- ☐HIV Positive
- ☐Kidney Disease
- ☐Liver Disease
- ☐Measles
- ☐Migraine Headaches
- ☐Miscarriage
- ☐Mononucleosis
- ☐Multiple Sclerosis
- ☐Mumps
- ☐Pacemaker
- ☐Pneumonia
- ☐Polio
- ☐Prostate Problem
- ☐Psychiatric Care
- ☐Rheumatic Fever
- ☐Scarlet Fever
- ☐Stroke
- ☐Suicide Attempts
- ☐Thyroid Problems
- ☐Tonsillitis
- ☐Tuberculosis
- ☐Typhoid Fever
- ☐Ulcers
- ☐Vaginal Infections
- ☐Venereal Disease

MEDICATIONS (List any you are currently taking- may continue on the back of this sheet)	**DOSAGE**	**FREQUENCY**	**ALLERGIES** to medications/substances

Preferred Pharmacy Name: _____ **Phone:** _____

(All information is strictly confidential)

PATIENTS NAME:

FAMILY HISTORY Fill in health information about your family

Check if any blood relatives had any of the following

Relation	Age	Age at death	Cause of death	☑	Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brother					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sister					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization

Have you ever had a blood transfusion? ☐Yes ☐No If yes, please list dates: _____

PREGNANCY HISTORY

# of pregnancies	# of live births	Complications (if any)

HEALTH HABITS: Check which substances you use and describe how often you use them

	Caffeine	
	Tobacco	
	Drugs	
	Alcohol	
	Other	

OCCUPATIONAL CONCERNS: Check if your work exposes you to the following

	Stress
	Hazardous Substances
	Heavy Lifting
	Other
Your	Occupation:

SERIOUS ILLNESS/INJURIES	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 his/her staff responsible for any errors or omissions that I may have made in completion of this form.

Signature: _____ **Date:** _____