HEALTH HISTORY

Date_____

Patient Name_____ Date of Birth_____

Please state the reason for your visit - _____

_____

Symptoms - check symptoms you currently have or have had in the past year.

GENERAL
__Chills
__Sweats
__Depression
__Dizziness
__Fainting
__Fever
__Forgetfulness
__Headache
__Loss of sleep
__Loss of weight
__Nervousness
__Numbness

GENITO-URINARY
__Blood in urine
__Frequent urination
__Painful urination
__Lack of bladder control

MUSCLE/JOINT/BONE
pain, weakness, numbness in:
__Arm __Hips
__Back __Legs
__Feet __Neck
__Hands __Shoulders

GASTROINTESTINAL
__Poor appetite
__Excessive appetite
__Excessive thirst
__Nausea
__Indigestion
__Stomach pain
__Vomiting
__Vomiting blood
__Gas
__Bloating
__Constipation
__Diarrhea
__Hemorrhoids
__Bowel changes
__Rectal bleeding

CARDIOVASCULAR
__Chest pain
__High blood pressure
__Irregular heart beat
__Low blood pressure
__Rapid heart beat
__Poor circulation
__Varicose veins

EYE, EAR, NOSE, THROAT
__Bleeding gums
__Blurred vision
__Crossed eyes
__Double vision
__Vision - flashes
__Vision - halos
__Loss of hearing
__Ringing in ears
__Earache
__Ear discharge
__Sinus problems
__Hay fever
__Hoarseness
__Nosebleeds
__Difficulty swallowing
__Persistent cough

SKIN
__Scars
__Rash
__Hives
__Itching
__Change in moles
__Bruise easily
__Sore that won't heal

MEN only
__Breast lump
__Erection difficulties
__Lump in testicle(s)
__Penis discharge
__Sore on penis
__other

WOMEN only
__Abnormal Pap Smear
__Abnormal bleeding
__Extreme menstrual pain
__Hot flashes
__Breast lump
__Nipple discharge
__Painful intercourse
__Vaginal discharge
__other

Date of last menstrual period_____
Date of last Pap Smear_____
Have you had a mammogram?_____
Are you pregnant?_____
Number of children_____

_____

CONDITIONS - check conditions you have now or have had at anytime in the past.

__AIDS
__Alcoholism
__Anemia
__Anorexia
__Appendicitis
__Asthma
__Bleeding disorder
__Bronchitis
__Bulimia
__Cancer
__Cataracts
__Chemical dependency
__Chicken Pox
__Diabetes
__Emphysema
__Epilepsy
__Goiter
__Gonorrhea
__Gout
__Heart disease
__Hepatitis
__Hernia
__Herpes
__High cholesterol
__HIV positive
__Kidney disease
__Liver disease
__Measles
__Migraine headache
__Mononucleosis
__Multiple Sclerosis
__Mumps
__Pacemaker
__Pneumonia
__Polio
__Prostate problem
__Psychiatric care
__Rheumatic Fever
__Scarlet Fever
__Stroke
__Suicide attempt
__Thyroid problems
__Tuberculosis
__Typhoid Fever
__Ulcer
__Vaginal infections
__Venereal disease

Please explain any checked symptoms or conditions if necessary:_____

_____

_____

_____

Please continue to Page 2 of Health History - thank you.

SURGERIES
Year Hospital Reason & Outcome

PREGNANCY HISTORY
Year born Sex Complications, if any

Have you ever had a blood transfusion? ___Yes ___No If yes, give approximate date(s):

SERIOUS ILLNESS/INJURIES - include date(s) and specifics:
__MRSA
__MI - myocardial infarction (heart attack)
__CHF - congestive heart failure
__CABG - coronary/cardiac artery bypass graft
__CRF - chronic renal failure
__HTN - hypertension, hypotension, high blood pressure
__Other-

FAMILY HISTORY -
Age State of health Cause of & age at death
Father
Mother
Siblings

Check if blood relatives have/had any of the following:
Relationship
__Arthritis,Gout
__Asthma, Hay fever
__Chemical Dependency
__Diabetes
__Heart disease/Stroke
__High blood pressure
__Kidney disease
__Tuberculosis

Health Habits - check the substances you use and describe how much you use:
__Caffeine
__Tobacco
__Non-prescription drugs
__Alcohol

Occupational concerns - check if your work exposes you to any of the following:
__Stress
__Heavy lifting
__Hazardous substances

Current Medications/dosages:

Preferred pharmacy

Allergies - medications/substances:

"I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member(s) of his/her staff responsible for any errors or omissions that I may have made in the completion of this form."
Signature
Date

Please continue to Page 3 of Health History - thank you.

HEALTH HISTORY - page 3

Patient Name_____ Chart Number_____

Date of birth_____ Date_____

1.) Please indicate in RED the areas where you have PAIN.

2.) Please indicate in BLUE the areas where you have NUMBNESS.