

# HEALTH HISTORY

Confidential

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Date of last physical examination \_\_\_\_\_

Reason for visit \_\_\_\_\_

## SYMPTOMS

Check (✓) symptoms you currently have or have had in the past year.

GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	MEN only
Chills	Appetite poor	Bleeding gums	Breast lump
Depression	Bloating	Blurred vision	Erection difficulties
Dizziness	Bowel changes	Crossed eyes	Lump in testicles
Fainting	Constipation	Difficulty swallowing	Penis discharge
Fever	Diarrhea	Double vision	Sore on penis
Forgetfulness	Excessive hunger	Earache	Other _____
Headache	Excessive thirst	Ear discharge	<b>WOMEN only</b>
Loss of sleep	Gas	Hay fever	Abnormal Pap Smear
Loss of weight	Hemorrhoids	Hoarseness	Bleeding between periods
Nervousness	Indigestion	Loss of hearing	Breast lump
Numbness	Nausea	Nosebleeds	Extreme menstrual pain
Sweats	Rectal bleeding	Persistent cough	Hot flashes
<b>MUSCLE/JOINT/BONE</b>	Stomach pain	Ringing in ears	Nipple discharge
Pain, weakness, numbness in:	Vomiting	Sinus problems	Painful intercourse
Arms      Hips	Vomiting blood	Vision — Flashes	Vaginal discharge
Back      Legs	<b>CARDIOVASCULAR</b>	Vision — Halos	Other _____
Feet      Neck	Chest pain	<b>SKIN</b>	Date of last menstrual period _____
Hands      Shoulders	High blood pressure	Bruise easily	Date of last Pap Smear _____
<b>GENITO-URINARY</b>	Irregular heart beat	Hives	Have you had a mammogram? _____
Blood in urine	Low blood pressure	Itching	Are you pregnant? _____
Frequent urination	Poor circulation	Change in moles	Number of children _____
Lack of bladder control	Rapid heart beat	Rash	
Painful urination	Swelling of ankles	Scars	
	Varicose veins	Sore that won't heal	

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<b>CONDITIONS</b>						
Check (✓) conditions you currently 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 Attempt	Thyroid Problems
Tonsillitis	Tuberculosis	Typhoid Fever	Ulcers	Vaginal Infections	Venereal Disease	
<b>MEDICATIONS</b>				<b>ALLERGIES</b>		
List medications you are currently taking.				List medications or substances that provoke a reaction.		
Pharmacy Name				Phone		
<b>FAMILY HISTORY</b>						
Fill in health information about your immediate family.						
Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if your blood relatives had any of the following:	
					Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

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HOSPITALIZATIONS			
Year	Hospital	Reason for hospitalization and the outcome	
<b>Have you ever had a blood transfusion?</b> Yes      No      If yes, please give approximate date. _____			
SERIOUS ILLNESS AND INJURIES			
Year	Type	Outcome	
PREGNANCY HISTORY			
Birth Year	Sex of Child	Complications if any	
<b>HEALTH HABITS</b> – Check (✓) which substances you use and describe how much you use.			
Caffeine			
Tobacco			
Alcohol			
Street Drugs			
Other			
<b>OCCUPATIONAL CONCERNS</b> – Check (✓) if your work exposes you to the following:			
Stress	Hazardous Substances	Heavy Lifting	Other
Your occupation: _____			

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_ Date \_\_\_\_\_

Print name of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_