

HEALTH HISTORY

Name _____ Today's Date _____

Age _____ Birthdate ____/____/____ Date of last physical exam _____

Occupation _____

Reason for today's visit _____

SYMPTOMS Check symptoms you currently have or have experienced in the last six months

<p>General</p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headaches <input type="checkbox"/> Lack of sleep <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Sweats <input type="checkbox"/> Weight loss / gain	<p>Gastrointestinal</p> <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Changes in appetite <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Heartburn <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting	<p>Eye, Ear, Nose, Throat</p> <input type="checkbox"/> Changes in vision <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Earache <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Date of Last Eye Exam: _____	<p>Men only</p> <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Sore on penis
<p>Muscles / Joints</p> <p>Pain, weakness or numbness in:</p> <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Back <input type="checkbox"/> Neck <input type="checkbox"/> Feet <input type="checkbox"/> Hands	<p>Cardiovascular</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heartbeat <input type="checkbox"/> Poor circulation <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	<p>Skin</p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Changes in moles <input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Sore that won't heal	<p>Women only</p> <input type="checkbox"/> Abnormal Pap <input type="checkbox"/> Breast lump <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge Date of last menstrual period _____ Date of last Pap _____ Date of last mammogram? _____ Birth control method (how you prevent pregnancy) _____ Are you pregnant? _____ Number of pregnancies ____ Number of children _____
<p>Genito-urinary</p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination	<input type="checkbox"/> Date of Last Colonoscopy: _____		

CONDITIONS Check conditions you have or have had in the past

<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Breast lump <input type="checkbox"/> Cancer (Type: _____) <input type="checkbox"/> Cataracts <input type="checkbox"/> Chemical dependency	<input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Eating disorder <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Gonorrhea / Chlamydia <input type="checkbox"/> Gout <input type="checkbox"/> Heart disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia	<input type="checkbox"/> Herpes <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> HIV positive <input type="checkbox"/> Kidney disease <input type="checkbox"/> Liver disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraines <input type="checkbox"/> Mumps <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pneumonia	<input type="checkbox"/> Polio <input type="checkbox"/> Prostate problems <input type="checkbox"/> Psychiatric care <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide attempt <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcers <input type="checkbox"/> Other: _____
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MEDICATIONS List medications you are currently taking and the dosage. Please include vitamins, supplements and birth control.

**** or I do not take ANY prescription medication whatsoever.

ALLERGIES List medicines you are allergic to and your reaction to them.

FAMILY HISTORY

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Sisters				
Brothers				

CHECK IF YOUR BLOOD RELATIVES HAD ANY OF THE FOLLOWING:

DISEASE	RELATIONSHIP TO YOU
<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Cancer (Which type _____)	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Tuberculosis	_____

HOSPITALIZATIONS

YEAR	HOSPITAL	REASON AND OUTCOME

PREGNANCY HISTORY

YEAR OF PREGNANCY	DATE OF BIRTH	COMPLICATIONS, IF ANY

HEALTH HABITS Check which substances you use or have used, and describe how much / often

<input type="checkbox"/> Tobacco (cigarettes, cigars, smokeless tobacco) _____
<input type="checkbox"/> Former tobacco user Date quit: _____
<input type="checkbox"/> Alcohol _____
<input type="checkbox"/> Caffeine _____
<input type="checkbox"/> Drugs (marijuana, cocaine, heroin, XTC, etc.) _____
<input type="checkbox"/> Advanced Directive on file <input type="checkbox"/> NO <input type="checkbox"/> YES (If yes, check which) <input type="checkbox"/> Living Will <input type="checkbox"/> Durable Power of Attorney for health care
Have you ever received a blood transfusion? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, please give approximate date _____

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 the completion of this form.

Signature

Date

Reviewed By

Date