HEALTH HISTORY
(Confidential)

Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

SYMPTOMS Mark (x) symptoms you currently have or have had in the past year

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain/Weekness/Numbness
- ☐ Shoulders, arms or hands
- ☐ Back, neck or hips
- ☐ Legs or feet

GENITO-URINARY
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of Bladder Control
- ☐ Painful Urination

GASTROINTESTINAL
- ☐ Poor Appetite
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ 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
- ☐ Persistant Cough
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

SKIN
- ☐ Bruise Easily
- ☐ Hives or Rash
- ☐ Itching
- ☐ Change in Moles
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast Lump
- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Penis Discharge
- ☐ Sore on Penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding Between Periods
- ☐ Breast Lump
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ 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 _____

MEDICATIONS List medications you are currently taking

ALLERGIES (To medications or Substances)

Pharmacy Name: Phone:

CONDITIONS Mark (x) 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 Problems
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

FAMILY HISTORY Fill in health information about your family.

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

Mark (x) if, your blood relatives had any of the following:

Disease	Relationship to you
☐ Arthritis, Gout	
☐ Asthma, Hay Fever	
☐ Cancer	
☐ Chemical Dependency	
☐ Diabetes	
☐ Heart Disease, Strokes	
☐ High Blood Pressure	
☐ Kidney Disease	
☐ Tuberculosis	
☐ Other	

Pregnancy History

Year & Sex of Birth	Complications (if any)

Have you ever had a blood transfusion?

☐ yes, date? _____ ☐ no

Health Habits Mark (x) which substances you use and how much.

Caffeine	☐	_____
Tobacco	☐	_____
Drugs	☐	_____
Other	☐	_____

HOSPITALIZATIONS

Hospital	Year	Reason for hospitalization & outcome

Serious Illnesses/Injuries	Outcome	Date

OCCUPATIONAL CONCERNS Mark (x) if your work exposes you to the following:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Your Occupation:

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