HEALTH HISTORY
(Confidential)

Name _____ **Birth Date** _____ **Today's Date** _____

Age _____ **Date of Last Physical Exam** _____ **Primary Physician** _____

Referring Physician _____ **Reason for Visit**: _____

Pharmacy Name, phone, address:_____

REVIEW OF SYSTEMS

Constitutional:
Y_ N _ Weight change
Y_ N _ Chills
Y_ N _ Fever
Y_ N _ Night Sweats
Y_ N _ Feeling tired or poorly (malaise)
Y _ Other constitutional symptoms

Ears, Nose Mouth, Throat:
Y _ N _ Loss of hearing on one side only
Y _ N _ Loss of hearing on both sides
Y _ N _ Ringing in the ears (tinnitus)
Y _ N _ Throat pain
Y _ N _ Soreness or pain of mouth
Y _ N _ Nosebleeds (epistaxis)

Genitourinary Symptoms:
Y _ N _ Hematuria (blood in urine)
Y _ N _ Dysuria (painful urination)
Y _ N _ Increased urinary frequency
Y _ N _ Urinary loss of control
Y _ Other genitourinary symptoms

Skin Symptoms:
Y _ N _ Pruritus (Itch)
Y _ N _ Skin lesions
Y _ N _ Rashes
Y _ Other skin symptoms

Neurological Symptoms:
Y _ N _ Dizziness
Y _ N _ Vertigo
Y _ N _ Motor disturbances
Y _ N _ Sensory disturbances
Y _ N _ Headache
Y _ Other neurological symptoms

Eyes:
Y _ N _ Eyesight problems
Y _ N _ Seeing double (diplopia)
Y _ N _ Worsening central vision
Y _ N _ Eye pain

Pulmonary Symptoms:
Y _ N _ Cough
Y _ N _ Coughing up blood (hemoptysis)
Y _ N _ Night sweats
Y _ N _ Wheezing
Y _ N _ Coughing up sputum
Y _ N _ Shortness of breath
Y _ Other pulmonary symptoms

Hematological Symptoms:
Y _ N _ Easy bleeding
Y _ N _ Easy bruising tendency
Y _ N _ Swollen glands in the neck
Y _ N _ Axillary lump

Endocrine Symptoms:
Y _ N _ Excessive sweating
Y _ N _ Excessive thirst (polydipsia)
Y _ N _ Temperature intolerance to heat (consistent)
Y _ N _ Temperature intolerance to cold (consistent)

Psychiatric Symptoms:
Y _ N _ Sleep disturbances
Y _ N _ Anxiety
Y _ N _ Depression
Y _ N _ Loss of pleasure from usual activities (anhedonia)
Y _ N _ Sense of impending doom
Y _ N _ Impulsive behavior

Gastrointestinal Symptoms:
Y _ N _ Constipation
Y _ N _ Heartburn
Y _ N _ Nausea
Y _ N _ Vomiting
Y _ N _ Abdominal pain
Y _ N _ Diarrhea
Y _ N _ Unable to restrain bowel movement
Y _ N _ Hematochezia
Y _ Other gastrointestinal symptoms

Cardiovascular Symptoms:
Y _ N _ Chest pain or discomfort
Y _ N _ Fast heart rate
Y _ N _ Palpitations
Y _ Other cardiovascular symptoms

Allergy:
Y _ N _ Nasal discharge watery
Y _ N _ Complaint of allergic reaction seasonal
Y _ N _ Complaint of allergic reaction from contact
Y _ N _ Complaint of allergic reaction from ingested food

Musculoskeletal:
Pain in the right:
Y _ N _ Shoulder
Y _ N _ Arm
Y _ N _ Hand
Y _ N _ Fingers
Y _ N _ Leg
Y _ N _ Foot
Pain in the left:
Y _ N _ Shoulder
Y _ N _ Arm
Y _ N _ Hand
Y _ N _ Fingers
Y _ N _ Leg
Y _ N _ Foot

Y _ N _ Hip pain
Y _ N _ Toes joint pain

TURN PAGE OVER

List Chronic Medical Problems For Which You are Treated by Other Physicians: _____

_____

_____

Do You Have a History of:

__ Anemia
__ Cancer
Types _____
__ Cataracts
__ Carpal tunnel syndrome
__ Diabetes
__ Emphysema
__ High cholesterol
__ Prostate problems
__ High blood pressure
__ Thyroid problems
__ Gout
__ Heart beat irregularity
__ Heart attack
__ Hepatitis
__ HIV
__ Liver disease
__ Migraines
__ Polio
__ Kidney stones

List Surgeries/Year Performed

_____

_____

_____

Have you had:

__ Brain surgery
__ Neck surgery
__ Lumbar spine surgery
__ Appendectomy
__ Gallbladder
__ Tonsillectomy/adenoidectomy
__ Hysterectomy
__ Pain Medications
__ Physical Therapy
__ Epidural Injections

Medications: _____

_____

Allergies: _____

If you had an MRI or other similar tests done since your last visit please list what type and where you had it/them done:

Test(s)_____**When**_____

Social History

How many children do you have? _____ Are you: Married _____ Single _____ Other _____
Did/Do You Smoke? ____ When did you quit? _____ Packs/day smoked? _____ #Years smoked? ____
How much wine/beer/hard liquor do you drink? _____
Current Occupation (if retired, former occupation) _____
Have you ever used marijuana, cocaine or injectable drugs? _____ Last time used? _____

Family History

	Alive Y/N	Age at Death	Cause of Death	Any diseases that run in your family list here
Mother				
Father				
Brothers				
Sisters				
Children				

_____ _____ _____

Patient's Signature **Date** **Physician's Signature**

Revised 1/2020