Health History & Database

Please complete both sides of this form completely. All information is confidential and is reviewed by your physician.

Patient Name: _____ Date of Birth: _____/_____/_____ Todays Date: _____/_____/_____

What is the reason for your visit? _____

Place a ✓ next to conditions you have now or have had in the past.							
	AIDS or HIV positive		Depression		High cholesterol		Psychiatric disorder
	Alcohol or drug addiction		Diabetes		Kidney disease		Rheumatic fever
	anemia		Diverticulosis		Kidney stones		Scarlet fever
	anorexia		Emphysema		Liver disease		Stroke
	Appendicitis		Epilepsy		Measles		Suicide attempt
	Arthritis		Glaucoma		Migraine headaches		Thyroid disorder
	Asthma		Goiter		Miscarriage		Tuberculosis
	Breast Disorder		Gout		Multiple sclerosis		Ulcers
	Bronchitis		Heart problem		Mumps		Urinary infections
	Bulimia		Heart attack		Pacemaker		Venereal disease
	Cataracts		Hepatitis		Pneumonia		
	Cancer		Hernia		Polio		
	Chicken Pox		Herpes		Prostate disorder		

List hospital admissions, operations, and illnesses or serious injuries. (not including pregnancies)

Year	**Illness or operation**	**Year**	**Illness or operation**

List all medications you are now taking including over the counter medications, supplements and vitamins.

Date of last Tetanus shot -	Date of last complete physical -	**Medication allergies -**
Date of last Flu shot -	Date of last Colonoscopy -	

To be completed by Female patients only	
Number of pregnancies -	Birth control method -
Number of live births -	Date of last menstrual period -
Number of abortions -	Date of last pap smear -
Number of miscarriages -	Date of last mammogram -

Family History If any blood relative has suffered any of the following, please indicate below with a ✓ and circle relation

	Alcohol abuse	mother	father	sibling	grandparent		Heart attack	mother	father	sibling	grandparent
	Anemia	mother	father	sibling	grandparent		High cholesterol	mother	father	sibling	grandparent
	Arthritis	mother	father	sibling	grandparent		Heart disease	mother	father	sibling	grandparent
	Asthma	mother	father	sibling	grandparent		Hypertension	mother	father	sibling	grandparent
	Bleeds easily	mother	father	sibling	grandparent		Kidney problems	mother	father	sibling	grandparent
	Cancer	mother	father	sibling	grandparent		Mental Illness	mother	father	sibling	grandparent
	Diabetes	mother	father	sibling	grandparent		Osteoporosis	mother	father	sibling	grandparent
	Drug abuse	mother	father	sibling	grandparent		Stroke	mother	father	sibling	grandparent
	Epilepsy	mother	father	sibling	grandparent		Thyroid problems	mother	father	sibling	grandparent
	Glaucoma	mother	father	sibling	grandparent		Tuberculosis	mother	father	sibling	grandparent

	Chills		High blood pressure		Decrease in urine flow/force		Lump in breast
	Fatigue		Irregular pulse		Loss of bladder control		Nipple discharge
	Fever		Leg pain		Painful or frequent urination		Non-healing sore
	Loss of appetite		Rapid heartbeat		Urethral discharge		Persistent rashes
	Sweats		Swollen ankles		Venereal Disease		Psoriasis or Eczema
	Weight gain		Varicose veins		Discharge from penis		Skin cancer or tumors
	Weight loss		Asthma or wheezing		Erectile difficulties		Dizzy or room spins
	Blurred vision		Bronchitis or cough		Lump in testicles		Frequent or severe HA's
	Double vision		Pneumonia or pleurisy		Prostate cancer		Memory loss
	Eye infection frequent		Shortness of breath		Sore on genitals		Numbness/tingling
	Eye Pain		Abdominal pain		Abnormal Pap Smear		Seizures
	Failing vision		Bloating		Irregular cycle		Stroke
	Bleeding gums		Bloody or tarry stools		Menstrual flow is heavy		Tremor/Hands shaking
	Decreased hearing		Change in bowel habits		Painful intercourse		Depression
	Difficulty swallowing		Constipation		Painful menstruation		Excessive moodiness
	Ear infections		Gallbladder problems		Vaginal discharge		Mental illness
	Ear pain		Heartburn		Arthritis or rheumatism		Nervousness
	hoarseness		Hemorrhoids		Back pain		Phobias
	Painful swallowing		Hernia		Bone fracture or joint injury		Sleeping Difficulties
	Nose bleeds		Jaundice or Hepatitis		Cold feet		Excessive hunger/thirst
	Ringing in ear		Nausea or vomiting		Gout		Flushing/menopause
	Sinus trouble		Rectal bleeding		Muscle weakness		Frequently hot
	Sore throats		Vomiting blood		Osteoporosis or thin bones		Hot Flashes
	Chest pain		Hay Fever or allergies		Pain? Location:		Anemia
	Dizzy spells		Hives				Swelling/lump, armpits
	Fainting spells		High blood pressure		Change in moles		Swelling/lump, groin
	Heart murmur		Severe allergic reaction		Easy bruising		Swelling/lump, neck

Symptoms: Mark (c) for current problems or ✓ for past problems:

Tobacco use -	Caffeinated beverages -
Alcohol use -	Occupation -
Drug use -	Exposure to hazardous substances -
Intravenous drug use -	Regular Exercise -
Do you have any special needs related to cultural beliefs? (i.e. diet, blood transfusions, religious practices) Yes or No If so please describe:	
Do you have any special educational or communication needs? YES NO	
Do you have any physical developmental or learning disabilities? YES NO	
Any food allergies or intolerances? YES NO	
Please circle the items listed that you have in your home: Smoke detector Carbon monoxide detector Extinguisher Firearms or Weapons	
Do you routinely wear your seatbelt? YES NO	
Do you wear a helmet while biking or rollerblading? YES NO	
Have you ever been the victim of domestic violence? YES NO	
Are you currently sexually active? YES NO	
Do you practice safe sex? YES NO	
Number of sexual partners in last YEAR? Number of partners in LIFETIME?	
Information completed by patient's family member or significant other? YES NO	
Previous Physician's and or office location with your medical records:	
Is English your primary language? If not, what is : YES NO	
The information above is accurate and complete to the best of my knowledge: Signature: Date: / /	
Reviewed: Date: / /	