HEALTH HISTORY (Confidential)

Name_____ Today's Date_____

Age _____ Birth date_____ Date of last physical exam _____

What is your reason for this visit? _____

SYMPTOMS Check 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, weakness, numbness in:
Arms
Back
Feet
Hands
Hips
Legs
Neck
Shoulders

GENITO-URINARY
Blood in urine
Frequent urination
Lack of bladder control
Painful urination

GASTROINTESTINAL
Appetite poor
Bloating
Bowel changes
Constipation
Diarrhea
Excessive hunger
Excessive thirst
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
Persistent cough
Ringing in ears
Sinus problems
Vision - Flashes
Vision - Halos

SKIN
Bruise easily
Hives
Itching
Changes in moles
Rash
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? _____
# of children _____

CONDITIONS Check conditions you currently have or have had in the past.

AIDS	Chemical Dependency	High Cholesterol	Prostate Problem
Alcoholism	Chicken Pox	HIV Positive	Psychiatric Care
Anemia	Diabetes	Kidney Disease	Rheumatic Fever
Anorexia	Emphysema	Liver Disease	Scarlet Fever
Appendicitis	Epilepsy	Measles	Stroke
Arthritis	Glaucoma	Migraine Headaches	Suicide Attempt
Asthma	Goiter	Miscarriage	Thyroid Problems
Bleeding Disorders	Gonorrhea	Mononucleosis	Tonsillitis
Breast lump	Gout	Multiple Sclerosis	Tuberculosis
Bronchitis	Heart Disease	Mumps	Typhoid Fever
Bulimia	Hepatitis	Pacemaker	Ulcers
Cancer	Hernia	Pneumonia	Vaginal Infections
Cataracts	Herpes	Polio	Venereal Disease

MEDICATIONS List medications you are currently taking	ALLERGIES To medications or substance

Pharmacy Name _____ Phone Number _____

HEALTH HISTORY - (Confidential)

FAMILY HISTORY —°Fill in health information about your family Check if your blood relatives had any of the following

Relation	Age	State of Health	Age at Death	Cause of Death		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	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

PREGNANCY HISTORY

Year of Birth	Sex of Baby	Complications if any

Have you ever had a blood transfusion? Yes No
If yes, please give approximate dates

Serious Illness/Injuries	Date	Outcome

HEALTH HABITS
Check which substance you use and amount

	Caffeine
	Tobacco
	Drugs
	Other

OCCUPATION CONCERNS
Check 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 have made in the completion of this form.

Signature: _____ Date: _____

Reviewed by: _____ Date: _____