Health History
(Confidential)

Name: _____ **Today's Date:** _____

Age: _____ **DOB:** _____ **Date of Last Physical Examination** _____

What is your reason for visit? _____

SYMPTOMS: Circle 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
- Loss 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
- Change in moles
- Rash
- Scars
- Sores that won't heal

MEN ONLY
- Breast lump
- Erectile 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 discourse
- Other

Date of last menstrual period: _____

Date of last pap smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

CONDITIONS: Circle symptoms you currently 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 Problem
- Psychiatric Care
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Suicide Attempt
- Thyroid Problems
- Tonsillitis
- Tuberculosis
- Typhoid Fever
- Ulcers
- Vaginal Infections
- Venereal Disease

MEDICATIONS: List medications you are currently taking	**ALLERGIES: To medications or substances**

Pharmacy Name: _____ **Pharmacy Phone:** _____

(All information is strictly confidential)

CONDITIONS: Check symptoms you currently have or have had in the past:

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

Check if your blood relatives have 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	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

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

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

YEAR OF BIRTH	SEX OF BIRTH	Complications, if any

HEALTH HABITS: Check which substances you use and describe how much you use

	Caffeine	
	Tobacco	
	Drugs	
	Other _____	
	Other _____	
	Other _____	

OCCUPATIONAL 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 may have made in the completion of this form

X _____ _____
PATIENT/GUARDIAN SIGNATURE DATE

X _____ _____
REVIEWED BY DATE