

# HEALTH HISTORY

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Date of last physical examination: \_\_\_\_\_

## SYMPTOMS - Check (✓) symptoms you currently have or have had in the past year.

<p><b>GENERAL</b></p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Loss of weight</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Sweats</p> <p><b>EYE, EAR, NOSE, THROAT</b></p> <p><input type="checkbox"/> Bleeding Gums</p> <p><input type="checkbox"/> Blurred vision</p> <p><input type="checkbox"/> Crossed eyes</p> <p><input type="checkbox"/> Difficulty swallowing</p> <p><input type="checkbox"/> Double vision</p> <p><input type="checkbox"/> Earache</p> <p><input type="checkbox"/> Ear discharge</p> <p><input type="checkbox"/> Hay fever</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Loss of hearing</p> <p><input type="checkbox"/> Nosebleeds</p> <p><input type="checkbox"/> Persistent cough</p> <p><input type="checkbox"/> Ringing in ears</p> <p><input type="checkbox"/> Sinus problems</p> <p><b>CARDIOVASCULAR</b></p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Irregular heart beat</p> <p><input type="checkbox"/> Low blood pressure</p> <p><input type="checkbox"/> Poor circulation</p> <p><input type="checkbox"/> Rapid heart beat</p> <p><input type="checkbox"/> Swelling in ankles</p>	<p><b>RESPIRATORY</b></p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Shortness of Breath</p> <p><input type="checkbox"/> Decrease in exercise capacity</p> <p><b>GASTROINTESTINAL</b></p> <p><input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> Appetite poor</p> <p><input type="checkbox"/> Bloating</p> <p><input type="checkbox"/> Bowel changes</p> <p><input type="checkbox"/> Constipation or diarrhea</p> <p><input type="checkbox"/> Gas</p> <p><input type="checkbox"/> Heartburn or indigestion</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Nausea or vomiting</p> <p><b>GENITO-URINARY</b></p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Frequent urinating</p> <p><input type="checkbox"/> Lack of bladder control</p> <p><input type="checkbox"/> Painful Urination</p> <p><b>MUSCLE/JOINT/BONE</b></p> <p>Pain, weakness, numbness in:</p> <p><input type="checkbox"/> Arms      <input type="checkbox"/> Hips</p> <p><input type="checkbox"/> Back      <input type="checkbox"/> Legs</p> <p><input type="checkbox"/> Feet      <input type="checkbox"/> Neck</p> <p><input type="checkbox"/> Hands      <input type="checkbox"/> Shoulders</p>	<p><b>SKIN</b></p> <p><input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> Hives</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Change in moles</p> <p><input type="checkbox"/> Rash</p> <p><input type="checkbox"/> Scars</p> <p><input type="checkbox"/> Sore that won't heal</p> <p><b>NEUROLOGICAL</b></p> <p><input type="checkbox"/> Dizziness or lightheadedness</p> <p><input type="checkbox"/> Weakness</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Seizures</p> <p><b>PSYCHIATRIC</b></p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Headache</p> <p><input type="checkbox"/> Loss of sleep</p> <p><input type="checkbox"/> Nervousness</p> <p><input type="checkbox"/> Stress</p> <p><input type="checkbox"/> Trouble concentrating</p> <p><b>ENDOCRINE</b></p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Hypertension</p> <p><input type="checkbox"/> Thyroid disease</p> <p><b>HEMATOLOGICAL</b></p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Bleeding disorder</p>	<p><b>ALLERGIES</b></p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Hayfever or allergic rhinitis</p> <p><b>WOMEN only</b></p> <p><input type="checkbox"/> Abnormal pap smear</p> <p><input type="checkbox"/> Bleeding between periods</p> <p><input type="checkbox"/> Breast lump</p> <p><input type="checkbox"/> Extreme menstrual pain</p> <p><input type="checkbox"/> Hot flashes</p> <p><input type="checkbox"/> Nipple discharge</p> <p><input type="checkbox"/> Painful intercourse</p> <p><input type="checkbox"/> Vaginal discharge</p> <p>Date of last menstrual period _____</p> <p>Date of last pap smear _____</p> <p>Have you had a mammogram? _____</p> <p>Are you pregnant? _____</p> <p>Number of children _____</p> <p><b>MEN only</b></p> <p><input type="checkbox"/> Erection difficulties</p> <p><input type="checkbox"/> Lump in testicles</p> <p><input type="checkbox"/> Penis discharge</p> <p>Date of last prostate exam _____</p>
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## CONDITIONS - Check (✓) conditions you have or have had in the past.

<p><input type="checkbox"/> AIDS</p> <p><input type="checkbox"/> Alcoholism</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Anorexia</p> <p><input type="checkbox"/> Appendicitis</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Bronchitis</p>	<p><input type="checkbox"/> Bulimia</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Cataracts</p> <p><input type="checkbox"/> Chemical dependency</p> <p><input type="checkbox"/> Chicken pox</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Epilepsy</p>	<p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Goiter</p> <p><input type="checkbox"/> Gonorrhea</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Heart disease</p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> Hernia</p> <p><input type="checkbox"/> Herpes</p>	<p><input type="checkbox"/> HIV positive</p> <p><input type="checkbox"/> Kidney disease</p> <p><input type="checkbox"/> Liver disease</p> <p><input type="checkbox"/> Measles</p> <p><input type="checkbox"/> Migraines</p> <p><input type="checkbox"/> Miscarriage</p> <p><input type="checkbox"/> Mononucleosis</p>	<p><input type="checkbox"/> Mumps</p> <p><input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Polio</p> <p><input type="checkbox"/> Prostate problem</p> <p><input type="checkbox"/> Psychiatric care</p> <p><input type="checkbox"/> Rheumatic fever</p>	<p><input type="checkbox"/> Scarlet fever</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Tonsilitis</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Typhoid fever</p> <p><input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> Venereal disease</p>
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**Please complete the back of this form also**

**PAST MEDICAL HISTORY:** List surgeries you have had and the year.

1.	2.
3.	4.

<b>MEDICATIONS:</b> List medications you are currently taking.	<b>ALLERGIES:</b> To medication or substances.
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1.	8.	
2.	9.	
3.	10.	
4.	11.	
5.	12.	
6.	13.	
7.	14.	

Pharmacy Name:	Phone:
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**Fill in health information about your family**

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

**PREGNANCY HISTORY:**

Year of Birth	Sex of Birth	Delivery Type	Complications if any

**SOCIAL HISTORY:**

Check (✓) the substance you use and describe how much you use.	
Caffeine	
Tobacco	
Alcohol	
Other	

**FAMILY HISTORY:**

List any illnesses that run in your family.	
1.	5.
2.	6.
3.	7.
4.	8.

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

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date Reviewed