HEALTH HISTORY FORM

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Date of Last Physical Exam: _____ Reason for Today's 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 ☐ Hips
☐ Back ☐ Legs
☐ Feet ☐ Neck
☐ Hands ☐ 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: _____
Pap Smear: _____
Have you had a mammogram? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No
Number of children? _____

CONDITIONS Check (✓) all conditions 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

MEDICATION List all medications you are currently taking

Medication:	Dosage:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES to medications or substances ☐ NKDA

_____

_____

PHARMACY List pharmacy contact information

Pharmacy Name: _____

Location (City): _____

Phone: _____ Fax: _____

(All Information is Confidential)

FAMILY HISTORY Fill in health information about your family.

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

Check (✓) if your blood relatives 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

PREGNANCY HISTORY

Year	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 substances you use and describe how much you use

☐	Caffeine	
☐	Tobacco	
☐	Drugs	
☐	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.

_____ _____

Signature Date

_____ _____

Reviewed By Date