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.

GENERAL
- ❑ Chills
- ❑ Dizziness
- ❑ Fainting
- ❑ Fever
- ❑ Loss of weight
- ❑ Numbness
- ❑ Sweats

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

CARDIOVASCULAR
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Low blood pressure
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Swelling in ankles

RESPIRATORY
- ❑ Cough
- ❑ Shortness of Breath
- ❑ Decrease in exercise capacity

GASTROINTESTINAL
- ❑ Abdominal pain
- ❑ Appetite poor
- ❑ Bloating
- ❑ Bowel changes
- ❑ Constipation or diarrhea
- ❑ Gas
- ❑ Heartburn or indigestion
- ❑ Hemorrhoids
- ❑ Nausea or vomitting

GENITO-URINARY
- ❑ Blood in urine
- ❑ Frequent urinating
- ❑ Lack of bladder control
- ❑ Painful Urination

MUSCLE/JOINT/BONE
- ❑ Arms ❑ Hips
- ❑ Back ❑ Legs
- ❑ Feet ❑ Neck
- ❑ Hands ❑ Shoulders

SKIN
- ❑ Bruise easily
- ❑ Hives
- ❑ Itching
- ❑ Change in moles
- ❑ Rash
- ❑ Scars
- ❑ Sore that won't heal

NEUROLOGICAL
- ❑ Dizziness or lightheadedness
- ❑ Weakness
- ❑ Fainting
- ❑ Seizures

PSYCHIATRIC
- ❑ Depression
- ❑ Headache
- ❑ Loss of sleep
- ❑ Nervousness
- ❑ Stress
- ❑ Trouble concentrating

ENDOCRINE
- ❑ Diabetes
- ❑ Hypertension
- ❑ Thyroid disease

HEMATOLOGICAL
- ❑ Anemia
- ❑ Bleeding disorder

ALLERGIES
- ❑ Asthma
- ❑ Hayfever or allergic rhinitis

WOMEN only
- ❑ Abnormal pap smear
- ❑ Bleeding between periods
- ❑ Breast lump
- ❑ Extreme menstrual pain
- ❑ Hot flashes
- ❑ Nipple discharge
- ❑ Painful intercourse
- ❑ Vaginal discharge

Date of last menstrual period _____

Date of last pap smear _____

Have you had a mammogram _____

Are you pregnant? _____

Number of children _____

CARDIOVASCULAR
- ❑ Erection difficulties
- ❑ Lump in testicles
- ❑ Penis discharge

Date of last prostate exam _____

CONDITIONS - Check (✓) conditions you have or have had in the past year.

- ❑ AIDS
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical dependency
- ❑ Chicken pox
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herpes
- ❑ HIV positive
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Measles
- ❑ Migraines
- ❑ Miscarriages
- ❑ Mononucleosis
- ❑ Mumps
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate problem
- ❑ Psychiatric care
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Stroke
- ❑ Tonsilitis
- ❑ Tuberculosis
- ❑ Typhoid fever
- ❑ Ulcers
- ❑ Venereal disease

Please complete the back of this form also

PAST MEDICAL HISTORY: List surgeries you have had and the year.	
1.	2.
3.	4.

MEDICATIONS: List medications you are currently taking.		ALLERGIES: To medications or substances.
1.	8.	
2.	9.	
3.	10.	
4.	11.	
5.	12.	
6.	13.	
7.	14.	
Pharmacy Name:		**Phone:**

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**