

HEALTH HISTORY

(Confidential)

Name: _____ Date: _____
 Age: _____ Birthdate: _____ Date of last physical: _____
 What is your reason for visit? _____

| SYMPTOMS (check ✓ symptoms you currently have or have had in the past year) | | | |
|---|--|--|--|
| GENERAL <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of Sleep <input type="checkbox"/> Loss of Weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats MUSCLE/JOINT/BONE Pain, weakness, numbness in: <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Shoulders <input type="checkbox"/> Hands <input type="checkbox"/> Neck GENITO-URINARY <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Frequent Urination <input type="checkbox"/> No bladder control <input type="checkbox"/> Painful Urination | GASTROINTESTINAL <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel Changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive Hunger <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Stomach Pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting Blood CARDIOVASCULAR <input type="checkbox"/> Chest Pain <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Rapid Heart Beat <input type="checkbox"/> Swelling of Ankles <input type="checkbox"/> Varicose Veins | EYE, EAR, NOSE, THROAT <input type="checkbox"/> Bleeding Gums <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Crossed Eyes <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Double Vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear Discharge <input type="checkbox"/> Hay Fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of Hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent Cough <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Vision – Flashes <input type="checkbox"/> Vision - Halos SKIN <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in Moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't Heal | MEN ONLY <input type="checkbox"/> Breast Lump <input type="checkbox"/> Erection Difficulties <input type="checkbox"/> Lump in Testicles <input type="checkbox"/> Penis Discharge <input type="checkbox"/> Sore on Penis WOMEN ONLY <input type="checkbox"/> Abnormal PAP Smear <input type="checkbox"/> Bleeding between Periods <input type="checkbox"/> Breast Lump <input type="checkbox"/> Menstrual Pain <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Vaginal Discharge Date of Last: Period _____ PAP Smear _____ Have you had a mammogram? _____ Are you Pregnant? _____ Number of Children _____ |
| CONDITIONS (check ✓ conditions you have or have had in the past) | | | |
| <input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts | <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes | <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraines <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio | <input type="checkbox"/> Prostate Problem <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Venereal Disease |
| MEDICATIONS (list all medications you are currently taking) | | | ALLERGIES |
| | | | |
| | | | |
| | | | |
| | | | |

PHARMACY NAME: _____

PHONE: _____

HEALTH HISTORY

(Confidential)

| FAMILY HISTORY Fill in health information about your family. | | | | | | |
|---|-----|-----------------|--------------|----------------|--|---------------------|
| Relation | Age | State of Health | Age at Death | Cause of Death | Check (✓) if your blood relatives had any of the following | |
| | | | | | Disease | Relationship to you |
| Father | | | | | Arthritis, Gout | |
| Mother | | | | | Asthma, Hay Fever | |
| Brothers | | | | | Cancer | |
| | | | | | Chemical Dependency | |
| | | | | | Diabetes | |
| | | | | | Heart Disease, Stroke | |
| Sisters | | | | | High Blood Pressure | |
| | | | | | Kidney Disease | |
| | | | | | Tuberculosis | |
| | | | | | Other | |

| HOSPITALIZATIONS | | |
|-------------------------|----------|--|
| Year | Hospital | Reason for Hospitalization and Outcome |
| | | |
| | | |
| | | |
| | | |
| | | |

| SERIOUS ILLNESS/ INJURIES | | |
|----------------------------------|-----------------|---------|
| Date | Injury/ Illness | Outcome |
| | | |
| | | |
| | | |
| | | |
| | | |

| PREGNANCY HISTORY | | | HEALTH HABITS | | OCCUPATIONAL CONCERNS | |
|--------------------------|--------------|------------------------|------------------------------------|----------|---|----------------------|
| Year of Birth | Sex of Birth | Complications (if any) | Check (✓) which & how much you use | | Check (✓) if your work exposes you to the following | |
| | | | | Caffeine | | Stress |
| | | | | Tobacco | | Hazardous Substances |
| | | | | Drugs | | Heavy Lifting |
| | | | | Other | | Other |
| | | | | | | Your Occupation: |

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

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