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 vomiting

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

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- ❑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_____

MEN only
- ❑Erection difficulties
- ❑Lump in testicles
- ❑Penis discharge

Date of last prostate exam _____

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

- ❑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
- ❑Miscarriage
- ❑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 medication 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** _____