

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 | ☐ Chemical Dependency | ☐ High Cholesterol | ☐ Prostate Problem |
| ☐ Alcoholism | ☐ Chicken pox | ☐ HIV Positive | ☐ Psychiatric Care |
| ☐ Anemia | ☐ Diabetes | ☐ Kidney Disease | ☐ Rheumatic Fever |
| ☐ Anorexia | ☐ Emphysema | ☐ Liver Disease | ☐ Scarlet Fever |
| ☐ Appendicitis | ☐ Epilepsy | ☐ Measles | ☐ Stroke |
| ☐ Arthritis | ☐ Glaucoma | ☐ Migraine Headaches | ☐ Suicide Attempt |
| ☐ Asthma | ☐ Goiter | ☐ Miscarriage | ☐ Thyroid Problems |
| ☐ Bleeding Disorders | ☐ Gonorrhea | ☐ Mononucleosis | ☐ Tonsillitis |
| ☐ Breast Lump | ☐ Gout | ☐ Multiple Sclerosis | ☐ Tuberculosis |
| ☐ Bronchitis | ☐ Heart Disease | ☐ Mumps | ☐ Typhoid Fever |
| ☐ Bulimia | ☐ Hepatitis | ☐ Pacemaker | ☐ Ulcers |
| ☐ Cancer | ☐ Hernia | ☐ Pneumonia | ☐ Vaginal Infections |
| ☐ Cataracts | ☐ Herpes | ☐ Polio | ☐ 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	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, Strokes	
Sisters					☐ High Blood Pressure	
					☐ Kidney Disease	
					☐ Tuberculosis	
					☐ Other	

HOSPITALIZATIONS

PREGNANCY HISTORY

Year	Hospital	Reason for Hospitalization and Outcome	Year	Complications (if any)

Have you ever had a blood transfusion? ☐ Yes ☐ No

HEALTH HABITS Check (✓) which substances you use and describe how much you use

☐ Caffeine	
☐ Tobacco	
☐ Drugs	
☐ Other	

If yes, please give approximate dates _____

SERIOUS ILLNESS / INJURIES	DATE	OUTCOME

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 _____