HEALTH HISTORY

Name _____ Today's Date _____
Age _____ Birthdate ____/____/____ Date of last physical exam _____
Occupation _____
Reason for today's visit _____

SYMPTOMS Check symptoms you currently have or have experienced in the last six months

General
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headaches
- ☐ Lack of sleep
- ☐ Loss of appetite
- ☐ Sweats
- ☐ Weight loss / gain

Muscles / Joints
Pain, weakness or numbness in:
- ☐ Arms ☐ Legs
- ☐ Back ☐ Neck
- ☐ Feet ☐ Hands

Genito-urinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Gastrointestinal
- ☐ Bloating
- ☐ Bowel changes
- ☐ Changes in appetite
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Vomiting

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

Eye, Ear, Nose, Throat
- ☐ Changes in vision
- ☐ Difficulty swallowing
- ☐ Earache
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems

Skin
- ☐ Bruise easily
- ☐ Changes in moles
- ☐ Itching
- ☐ Rash
- ☐ Sore that won't heal

Men only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Sore on penis

Women only
- ☐ Abnormal Pap
- ☐ Breast lump
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge

Date of last menstrual period _____
Date of last Pap_____
Date of last mammogram? _____
Birth control method (how you prevent pregnancy)_____
_____
Are you pregnant? _____
Number of pregnancies ____
Number of children _____

CONDITIONS Check conditions you have or have had in the past

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Cancer (Type:_____)
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Eating disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gonorrhea / Chlamydia
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraines
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problems
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other:_____
_____

MEDICATIONS List medications you are currently taking and the dosage. Please include vitamins, supplements and **birth control**.

_____
_____
_____
_____

**** or ☐ I do not take ANY prescription medication whatsoever.

ALLERGIES List **medicines** you are allergic to and your reaction to them.

_____
_____
_____

FAMILY HISTORY

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

CHECK IF YOUR BLOOD RELATIVES HAD ANY OF THE FOLLOWING:

DISEASE	RELATIONSHIP TO YOU
☐ Asthma	_____
☐ Cancer (Which type _____)	_____
☐ Diabetes	_____
☐ Heart Disease	_____
☐ High Blood Pressure	_____
☐ Stroke	_____
☐ Tuberculosis	_____

HOSPITALIZATIONS

YEAR	HOSPITAL	REASON AND OUTCOME

PREGNANCY HISTORY

YEAR OF PREGNANCY	DATE OF BIRTH	COMPLICATIONS, IF ANY

HEALTH HABITS Check which substances you use or have used, and describe how much / often

☐ Tobacco (cigarettes, cigars, smokeless tobacco)_____
☐ Former tobacco user Date quit:_____
☐ Alcohol _____
☐ Caffeine _____
☐ Drugs (marijuana, cocaine, heroin, XTC, etc.) _____
☐ Advanced Directive on file ☐ NO ☐ YES (If yes, check which) ☐ Living Will ☐ Durable Power of Attorney for health care
Have you ever received a blood transfusion? ☐ NO ☐ YES **If yes, please give approximate date** _____

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