HEALTH HISTORY

PATIENT NAME_____ BIRTHDATE____/____/____ PATIENT #_____

This history form provides us with information to help us meet all your healthcare needs, please complete both sides of this form answering each question. **This is a confidential part of your medical record and will be kept in this office.**

Today's date_____
Place of Birth_____
Highest level in school_____
Occupation_____
Previous occupations_____
Marital status_____
Hobbies_____
Exercise/recreation_____
Habits:
Smoking (type & amount per day)_____
If former smoker, date quit_____
Alcohol (type & amount per week)_____
Caffeine (type & amount per day)_____
Street drugs (type & amount per day)_____
Usual weight_____My ideal weight_____
Date of last dental exam_____
Please list all allergies (foods, drugs, environment)_____
_____
_____
_____

When was your last physical exam?_____
Name of doctor_____Phone_____
Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred:
_____
_____
_____
_____
_____
Please list all medicines you are currently taking (include nonprescription drugs):
_____
_____
_____
_____
Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred):
_____
_____
_____
Any history of family violence?_____

CHIEF COMPLAINTS

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

_____
_____

PAST MEDICAL HISTORY

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	Heart Disease	no	yes	Diabetes	no	yes
Mumps	no	yes	Arthritis	no	yes	Cancer	no	yes
Chickenpox	no	yes	Venereal Disease	no	yes	Polio	no	yes
Whooping Cough	no	yes	Anemia	no	yes	Glaucoma	no	yes
Scarlet Fever	no	yes	Bladder Infections	no	yes	Hernia	no	yes
Diptheria	no	yes	Epilepsy	no	yes	Blood or Plasma Transfusions	no	yes
Smallpox	no	yes	Migraine Headaches	no	yes	Back trouble	no	yes
Pneumonia	no	yes	Tuberculosis	no	yes	High/low Blood Pressure	no	yes
Rheumatic Fever	no	yes				Hemorrhoids	no	yes

PAST MEDICAL HISTORY cont.

Date of last Chest x-ray _____

Asthma	no	yes
Hives/Eczema	no	yes
AIDS or HIV+	no	yes
Infectious Mono	no	yes
Bronchitis	no	yes
Mitral Valve Prolapse	no	yes
Stroke	no	yes
Hepatitis	no	yes
Ulcer	no	yes
Kidney disease	no	yes
Thyroid Disease	no	yes
Bleeding Tendency	no	yes
Any other Disease	no	yes

(Please list)_____
_____

FAMILY HISTORY

Has any blood relative had any of the following: (Circle "no" or "yes", leave blank if uncertain)

		Relationship			Relationship
Cancer	no	yes_____	Depression	no	yes_____
Tuberculosis	no	yes_____	Psychosis	no	yes_____
Diabetes	no	yes_____	Suicide	no	yes_____
Heart disease	no	yes_____	Leukemia	no	yes_____
High blood Pressure	no	yes_____	Migraine Headaches	no	yes_____
Stroke	no	yes_____	Obesity	no	yes_____
Epilepsy	no	yes_____	Thyroid Disease	no	yes_____
Allergies	no	yes_____	Ulcer	no	yes_____
Anemia	no	yes_____	High Cholesterol	no	yes_____
Bleeding Tendency	no	yes_____	Kidney Disease	no	yes_____
Asthma	no	yes_____	Glaucoma	no	yes_____
Chronic Lung Disease	no	yes_____	Gout	no	yes_____
Drug/Alcohol Problem	no	yes_____			

List the present age or the age of death of each of the following members of your family, also if living add if their health is good, fair, or poor. If deceased, list the cause of death.

Father_____
Mother_____
Brother_____
_____
_____
Sister_____
_____
_____
Spouse_____

Son_____
_____
_____
Daughter_____
_____
_____

MEDICAL HISTORY cont.

Do you have now or have you had within the past year:
(Please circle the correct response beside each question)

Weakness or Paralysis never occasionally often
Tire easily never occasionally often
Weight Change never occasionally often
Change in Appetite never occasionally often
Sensitivity to Cold or heat never occasionally often
Persistent Fever never occasionally often
Night sweats never occasionally often
Hot flashes never occasionally often
Skin rash never occasionally often
Skin problems never occasionally often
Change in nails Or hair never occasionally often
Headaches never occasionally often
Easy bleeding never occasionally often
Easy bruising never occasionally often
Double vision never occasionally often
Blurred vision never occasionally often
Eye pain never occasionally often
Infected eyes never occasionally often
Do you wear Glasses or Contacts never occasionally often
Last eye exam _____
Ringing in Ears never occasionally often
Discharge From ears never occasionally often
Ear pain never occasionally often
Hearing loss never occasionally often
Frequent nose Bleeds never occasionally often
Frequent colds never occasionally often
Sinus problems never occasionally often
Loss of smell never occasionally often
Persistent Hoarseness never occasionally often
Sore throat never occasionally often

Sore tongue Or gums never occasionally often
Breast lump or Discharge never occasionally often
Chronic cough never occasionally often
Shortness of Breath never occasionally often
Bloody sputum never occasionally often
Wheezing never occasionally often
Chest pain or Discomfort never occasionally often
Purple fingers Or lips never occasionally often
Swelling of hands Feet or ankle never occasionally often
Difficulty Breathing never occasionally often
Palpitations or Fluttering of Heart never occasionally often
Leg cramps never occasionally often
Enlarged veins never occasionally often
Difficulty Swallowing never occasionally often
Heartburn never occasionally often
Frequent Belching never occasionally often
Abdominal Cramping never occasionally often
Nausea never occasionally often
Vomiting never occasionally often
Vomited or Coughed up Blood never occasionally often
Chronic Diarrhea never occasionally often
Chronic Constipation never occasionally often
Rectal bleeding never occasionally often
Black tarry Stools never occasionally often
Dark urine never occasionally often

Yellow jaundice never occasionally often
Frequent (day) Urination never occasionally often
Frequent (night) Urination never occasionally often
Increase in Thirst never occasionally often
Painful Urination never occasionally often
Leakage of Urine never occasionally often
Difficulty Starting Urine never occasionally often
Blood in urine never occasionally often
Lack of sex Drive never occasionally often
Hemorrhoids never occasionally often
Backaches never occasionally often
Joint pain or Stiffness never occasionally often
Swollen joints never occasionally often
Muscle cramps Or spasms never occasionally often
Sleeplessness never occasionally often
Seizures never occasionally often
Depression never occasionally often
Memory loss never occasionally often
Poor Coordination never occasionally often
Dizziness never occasionally often
Fainting never occasionally often

Men only:
Discharge from Penis never occasionally often
Pain or lump In testicles never occasionally often
Impotence never occasionally often

Women only:
Age period began_____
# of days period lasts_____
Days between periods_____

MEDICAL HISTORY cont.

Is your flow Heavy? never occasionally often

Do you bleed Or spot between periods never occasionally often

Do you have Pain or Cramps? never occasionally often

Date of last period_____

Date of last pelvic Exam_____

Date of last Mammogram_____

Any itching in the Vaginal Area never occasionally often

Pain with Intercourse never occasionally often

Type of birth Control used_____

Number of pregnancies_____

Number of full term Births_____

Number of preterm Births_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary health care services I may need.

Signature_____Date_____

Physician's comment

Physician's Signature_____