HEALTH HISTORY

Today's date_______________________________

PATIENT NAME__________________________BIRTHDATE____/____/____ Social Security #________

This history form provides us with information to help us meet all your healthcare needs. **This is a confidential part of your medical record and will be maintained confidentially.**

Place of Birth______________________________
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)______________
Usual weight_______My ideal weight___________
Date of last dental exam_____________________
Date of last eye exam_______________________
Date of last skin 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:

1)_______________________________________3)____
2)_______________________________________4) ____

PAST MEDICAL HISTORY

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

			Anemia	no	yes	Transfusion	no	yes
Chickenpox	no	yes				High Blood Pressure	no	yes
Pneumonia	no	yes	Urinary Tract Infections	no	yes	Asthma	no	yes
Rheumatic Fever	no	yes	Seizure	no	yes	Stroke	no	yes
Tuberculosis	no	yes	Migraines	no	yes	Hepatitis	no	yes
Heart Disease	no	yes	Diabetes	no	yes	Ulcer	no	yes
Arthritis	no	yes	Glaucoma	no	yes			

Date of Last Pap smear_______
Date of Last Mammogram______
Date of Last Colonoscopy or Sigmoidoscopy___________

FAMILY HISTORY

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

Condition		Relationship
Cancer	no	yes_____________________
Tuberculosis	no	yes_____________________
Diabetes	no	yes_____________________
Heart disease	no	yes_____________________
High blood Pressure	no	yes_____________________
Stroke	no	yes_____________________
Seizures	no	yes_____________________
Allergies	no	yes_____________________
Anemia	no	yes_____________________
Bleeding Tendency	no	yes_____________________
Asthma	no	yes_____________________
Chronic Lung Disease	no	yes_____________________
Drug/Alcohol Problem	no	yes_____________________
Depression	no	yes_____________________
Psychosis	no	yes_____________________
Suicide	no	yes_____________________
Leukemia	no	yes_____________________
Migraine Headaches	no	yes_____________________
Obesity	no	yes_____________________
Thyroid Disease	no	yes_____________________
Ulcer	no	yes_____________________
High Cholesterol	no	yes_____________________
Kidney Disease	no	yes_____________________
Glaucoma	no	yes_____________________
Gout	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 never occasionally ofte
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

Women only:
Age period began__________
Have you been diagnosed as
menopausal? _______
When did your periods end?____
Have you used Hormone
replacement therapy ______
Do you have any ongoing vaginal
bleeding or spotting?________
Loss of libido?_________

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_______________________________________