

Health History

Name: _____ Birth Date: _____

Today's Date: _____ Date of last physical exam: _____

Symptoms Check (✓) symptoms you currently have or have had in the past year

GENERAL

- Chills
- 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

GASROINTESTINAL

- Abdominal Pain
- Poor Appetite
- Bloating
- Bowel Changes
- Constipation or diarrhea
- Gas
- Heartburn or indigestion
- 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

HEMATOLOGICAL

- Anemia
- Bleeding Disorder

SKIN

- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars

Sores that won't heal

NEUROLOGICAL

- Dizziness
- Weakness
- Fainting
- Seizures

PSYCHIATRIC

- Depression
- Headache
- Loss of sleep
- Nervousness
- Stress

ENDOCRINE

- Diabetes
- Hypertension
- Thyroid Disease

ALLERGIES

List:

CONDITIONS Please (✓) conditions you have or have had in the past

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Goiter | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Gout | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Polio | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Stroke | <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Typhoid Fever | | <input type="checkbox"/> Venereal Disease | |

PAST MEDICAL HISTORY: List surgeries you had and what year they were done

1. _____ 2. _____

3. _____ 4. _____

MEDICATIONS: List medications you are currently taking

ALLERGIES: To medications or substances

1. _____	2. _____	_____
3. _____	4. _____	_____
5. _____	6. _____	_____
7. _____	8. _____	_____
9. _____	10. _____	_____

Pharmacy Name: _____ **Phone:** _____

Fill in health information about your family

	Age	State of Health	Age at Death	Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother's	_____	_____	_____	_____
	_____	_____	_____	_____
Sister's	_____	_____	_____	_____
	_____	_____	_____	_____

SOCIAL HISTORY Check (✓) the substance you use and describe how much you use

- Caffeine _____
- Tobacco _____
- Alcohol _____
- Other _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members or his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient

Date

Physician Signature

Date Reviewed