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HEALTH HISTORY

PATIENT NAME: ____ **BIRTHDATE:** __________________ **DATE:** _______________

To help us meet your healthcare needs, please fill out BOTH SIDES of this form completely. This is a confidential record of your medical history and will be kept in this office.

Chief Complaint(s): Please list your top five health concerns, symptoms, or problems: ____
____

Place of birth: ____
Occupation: ____
Previous occupation(s): ____________________________________
Marital status: ____
Exercise: ____
Alcohol (type and amount/day): _____________________________
Caffeine (type and amount/day): ____________________________
Water (amount/day): ______________________________________
Smoking (type and amount/day): ____________________________
If former smoker, date quit: _______________________
Street drugs (type and amount/day): _________________________
Please list all allergies (foods, drugs, and environmental):
____
____
Height: ________________ Usual weight: __________________
Date of last dental exam: __________________________________
Date of last eye exam: ____________________________________

Date of last physical exam: ________________________________
Doctor: _______________ Phone: ___________________
Please list all medicines you are currently taking: ☐ None
____
____
____
Please list all supplements you are currently taking: ☐ None
____
____
____
Please list all serious illnesses, operations, injuries, head injuries, fractures or broken bones, and other hospitalizations you have experienced. Include the year these occurred: ☐ None
____
____
____
____

Past Medical History: Have you **ever** had the following? Circle "no" or "yes". Leave blank if uncertain.

Condition			Condition			Condition		
Measles	no	yes	Epilepsy	no	yes	Hives	no	yes
Mumps	no	yes	Migraines	no	yes	Eczema	no	yes
Chickenpox	no	yes	Tuberculosis	no	yes	AIDS or HIV +	no	yes
Whooping cough	no	yes	Diabetes	no	yes	Infectious Mono	no	yes
Scarlet fever	no	yes	Cancer	no	yes	Bronchitis	no	yes
Diphtheria	no	yes	Polio	no	yes	Stroke	no	yes
Smallpox	no	yes	Glaucoma	no	yes	Hepatitis	no	yes
Pneumonia	no	yes	Hernia	no	yes	Ulcer	no	yes
Rheumatic fever	no	yes	Blood/Plasma transfusions	no	yes	Kidney disease	no	yes
Heart disease	no	yes	Back trouble	no	yes	Thyroid disease	no	yes
Arthritis	no	yes	High blood pressure	no	yes	Bleeding tendency	no	yes
Venereal disease	no	yes	Low blood pressure	no	yes	Any other disease	no	yes
Anemia	no	yes	Hemorrhoids	no	yes	Please list: ______________________		
Bladder infections	no	yes	Asthma	no	yes	___________________________________		

Vaccine History: Please list vaccine history—be as specific as possible. ____
____
____

Family History: Has any blood relative had any of the following? Circle "no" or "yes". Leave blank if uncertain.

Condition			Condition			Condition		
Cancer	no	yes	Allergies	no	yes	Obesity	no	yes
Type: __________________________			Anemia	no	yes	Low thyroid function	no	yes
Tuberculosis	no	yes	Bleeding tendency	no	yes	High thyroid function	no	yes
Diabetes	no	yes	Asthma	no	yes	Ulcer	no	yes
Heart disease	no	yes	Depression	no	yes	High cholesterol	no	yes
High blood pressure	no	yes	Alzheimer's	no	yes	Kidney disease	no	yes
Stroke	no	yes	Leukemia	no	yes	Glaucoma	no	yes
Epilepsy	no	yes	Migraines	no	yes	Gout	no	yes

Please complete reverse side →

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Family History (continued):

Present age or age of death: If living, health (good, fair, poor). If deceased, cause of death:

Father: ____

Mother: ____

Siblings: ____
____
____

Spouse: ____

Children: ____
____
____

Do you have <u>now</u> or have you had <u>within the past year</u>: Circle "no" or "yes".

Weakness . . . . no yes
Paralysis . . . . no yes
Fatigue . . . . no yes
Unexplained weight change. . no yes
Appetite change . . . . no yes
Cold sensitivity . . . . no yes
Heat sensitivity . . . . no yes
Persistent fever . . . . no yes
Night sweats . . . . no yes
Hot flashes . . . . no yes
Skin rash . . . . no yes
Skin trouble . . . . no yes
Hair changes . . . . no yes
Nail changes . . . . no yes
Headaches . . . . no yes
Easy bleeding . . . . no yes
Easy bruising . . . . no yes
Double vision . . . . no yes
Blurred vision . . . . no yes
Eye pain . . . . no yes
Infected eyes . . . . no yes
Do you wear glasses or
contacts? . . . . no yes
Ringing in ears . . . . no yes
Ear discharge . . . . no yes
Reduced hearing . . . . no yes
Frequent nosebleeds . . . . no yes
Frequent colds . . . . no yes
Sinus trouble . . . . no yes
Loss of smell . . . . no yes
Persistent hoarseness . . . . . . no yes
Sore throat . . . . no yes
Sore tongue . . . . no yes
Sore gums . . . . no yes
A persistent cough or throat clearing
not associated with a known
illness . . . . no yes

Lump or discharge
from breast . . . . no yes
Shortness of breath . . . . no yes
Bloody sputum . . . . no yes
Wheezing . . . . no yes
Chest pain . . . . no yes
Purple fingers or toes . . . . . . no yes
Swelling of hands, feet, or
ankles . . . . no yes
Difficulty breathing . . . . .no yes
Palpitations/Heart fluttering . no yes
Enlarged veins . . . . no yes
Difficulty swallowing . . . . . . no yes
Heartburn . . . . no yes
Frequent belching . . . . no yes
Abdomen cramps . . . . no yes
Nausea . . . . no yes
Vomiting . . . . no yes
Vomited or coughed up
blood . . . . no yes
Chronic diarrhea . . . . no yes
Chronic constipation . . . . . . no yes
How often do you have a BM? _________
Hemorrhoids . . . . no yes
Rectal bleeding . . . . no yes
Blood in stool . . . . no yes
Mucus in stool . . . . no yes
Undigested food in stool . . . no yes
Black tarry stools . . . . no yes
Dark urine . . . . no yes
Yellow jaundice . . . . no yes
Frequent urination . . . . no yes
Increased thirst . . . . no yes
Painful urination . . . . no yes
Leakage of urine . . . . no yes
Difficulty starting urine flow. no yes
Blood in urine . . . . no yes
Lack of sex drive . . . . no yes

Backaches . . . . no yes
Leg cramps . . . . no yes
Joint pain or stiffness . . . . . . no yes
Swollen joints . . . . no yes
Muscle cramps . . . . no yes
Sleeplessness . . . . no yes
Seizures . . . . no yes
Depression . . . . no yes
Memory loss . . . . no yes
Clumsiness . . . . no yes
Dizziness . . . . no yes
Fainting . . . . no yes

Men only:

Discharge from penis . . . . . . no yes
Pain in testicles . . . . no yes
Lump in testicles . . . . no yes
Impotence . . . . no yes

Women only:

Age period began: ___________________
Days periods bleed: _________________
Days between periods: _______________
Date of last period: _________________
Date of last pelvic exam: ______________
Date of last mammogram: _____________
Abnormal PAP in past . . . . . no yes
Heavy flow . . . . no yes
Bleed or spot between
periods. . . . . no yes
Pain or cramps . . . . no yes
Vaginal itching . . . . no yes
Pain with intercourse . . . . . . no yes
Type of birth control used: ____________
Number of pregnancies: ______________
Number of full-term births: ____________
Number of pre-term 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 (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

Signature of patient (or parent if minor): ____ Date: ____________________

Please complete reverse side →