HEALTH HISTORY

Patient Name: _____ **Birthdate** ____/____/____ **Patient #** _____

To help us meet all your health care needs, Please fill out **both sides** of this form completely in ink. This is a confidential record of your medical history and will be kept in this office.

Today's date: _____
Highest level in school _____
Occupation _____
Previous occupations _____
Martial status _____
Habits:
Smoking (type & amount per day) _____
If former smoker, date quit _____
Alcohol (type & amount per week) _____
Street drugs (type & amount per day) _____
Usual weight _____
Please list all allergies (foods, drugs, environment) _____
_____
_____
_____

When was your last physical exam? _____
Name of doctor _____
Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred: _____ none
_____
_____
_____
_____
_____

Please list all medicines you are currently taking (include nonprescription drugs): _____none
_____
_____
_____

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)

Pneumonia	no	yes	Migraine headaches	no	yes	Hives or Eczema	no	yes
Rheumatic Fever	no	yes	Tuberculosis	no	yes	AIDS or HIV +	no	yes
Heart Disease	no	yes	Diabetes	no	yes	High or low blood pressure	no	yes
Arthritis	no	yes	Cancer	no	yes	Back trouble	no	yes
Venereal Disease	no	yes	Polio	no	yes	Ulcer	no	yes
Anemia	no	yes	Glaucoma	no	yes	Infectious Mono	no	yes
Bladder Infections	no	yes	Hemorrhoids	no	yes	Hepatitis	no	yes
Epilepsy	no	yes	Asthma	no	yes	Mitral Valve Prolapse	no	yes
Blood or Plasma Transfusions	no	yes	Stroke	no	yes	Bleeding tendency	no	yes
Thyroid Disease	no	yes	Bronchitis	no	yes	Any other disease _____		
			Kidney Disease	no	yes			

Family History

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

		Relationship			Relationship
Cancer	no .... yes	.....	Stroke	no .... yes	.....
Diabetes	no .... yes	.....	Bleeding tendency	no .... yes	.....
Heart Disease	no .... yes	.....	Anemia	no .... yes	.....
High blood pressure	no .... yes	.....	Obesity	no .... yes	.....
Leukemia	no .... yes	.....	Depression	no .... yes	.....
High Cholesterol	no .... yes	.....	High Cholesterol	no .... yes	.....
Gout	no .... yes	.....	Kidney Disease	no .... yes	.....

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Family History (cont.)

	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 now or have you had within the past year:
(Circle "no" or "yes", leave blank if uncertain)

Weakness or paralysis	no	yes	Bloody sputum	no	yes	Joint paint or stiffness	no	yes
Tire easily or weakness	no	yes	Wheezing	no	yes	Swollen joints	no	yes
Recent weight changes	no	yes	Chest pain or discomfort	no	yes	Muscle cramps	no	yes
Change in appetite	no	yes	Purple fingers or lips	no	yes	Sleeplessness	no	yes
Sensitivity to cold or heat	no	yes	Swelling of hands or feet	no	yes	Seizures	no	yes
Persistent fever	no	yes	Difficulty in breathing	no	yes	Depression	no	yes
Night sweats or hot flashes	no	yes	Palpitations of the heart	no	yes	Memory loss	no	yes
Skin rash	no	yes	Leg cramps	no	yes	Poor coordination	no	yes
Skin trouble or changes	no	yes	Enlarged veins	no	yes	Dizziness or fainting		
Change in nails or hair	no	yes	Difficulty swallowing	no	yes	spells	no	yes
Headaches	no	yes	Heartburn	no	yes	A living will or		
Easy bleeding or bruising	no	yes	Frequent belching	no	yes	advance directive	no	yes
Double vision	no	yes	Abdominal cramping	no	yes	**Men only:**		
Blurred vision	no	yes	Nausea	no	yes	Discharge from penis	no	yes
Eye pain	no	yes	Vomiting	no	yes	Pain or lump in testicles	no	yes
Infected eyes	no	yes	Vomited or coughed up blood	no	yes	Impotence	no	yes
Do you wear glasses	no	yes	Chronic diarrhea	no	yes	**Women only:**		
When was your last eye exam _____			Chronic constipation	no	yes	Age period began _____		
Ringing in the ears	no	yes	Rectal bleeding	no	yes	How many days do periods last? ____		
Discharge from ears	no	yes	Black tarry stools	no	yes	How many days between periods?		
Ear pain	no	yes	Dark urine	no	yes	_____		
Decrease in hearing	no	yes	Yellow jaundice	no	yes	Is the flow heavy?	no	yes
Frequent nosebleeds	no	yes	Frequent urination (day)	no	yes	Do you bleed or spot		
Frequent colds	no	yes	Frequent urination (night)	no	yes	between periods?	no	yes
Sinus trouble	no	yes	Increase in thirst	no	yes	Date of last period? _____		
Loss of smell	no	yes	Painful urination	no	yes	Date of last pelvic exam? _____		
Persistent hoarseness	no	yes	Leakage of urine	no	yes	Date of last mammogram? _____		
Sore throat	no	yes	Difficulty in starting urine	no	yes	Number of pregnancies _____		
Sore tongue or gums	no	yes	Blood in urine	no	yes	Number of full term births _____		
Lump or discharge from breast	no	yes	Lack of sex drive	no	yes	Number of preterm births _____		
Chronic or frequent cough	no	yes	Hemorrhoids	no	yes			
Shortness of breath	no	yes	Backaches	no	yes			

X _____
Signature of patient or parent if minor

_____/_____/_____
Date