

HEALTH HISTORY

PATIENT NAME _____ BIRTHDATE ____/____/____

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 and type of reaction (foods, drugs, environment) _____

When was your last physical exam? _____
 Name of doctor _____
 Please list all medical illnesses, operations, or hospitalizations you have experienced and indicate year these occurred:

Please list all medicines you are currently taking and dosages (include nonprescription drugs):

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	Arthritis	no	yes	Polio	no	yes
Mumps	no	yes	Venereal			Glaucoma	no	yes
Chickenpox	no	yes	Disease	no	yes	Hernia	no	yes
Whooping			Anemia	no	yes	Blood or Plasma		
Cough	no	yes	Bladder			Transfusions	no	yes
Scarlet Fever	no	yes	Infections	no	yes	Back trouble	no	yes
Diphtheria	no	yes	Epilepsy	no	yes	High/low Blood		
Smallpox	no	yes	Migraine			Pressure	no	yes
Pneumonia	no	yes	Headaches	no	yes	Hemorrhoids	no	yes
Rheumatic			Tuberculosis	no	yes			
Fever	no	yes	Diabetes	no	yes			
Heart Disease	no	yes	Cancer	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. Please list all medical illnesses (cancer, diabetes, heart disease, etc).

Father _____

 Mother _____

 Brother(s) _____

 Sister(s) _____

Spouse _____
 Son(s) _____

 Daughter(s) _____

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 _____

Do you bleed

Or spot between
periods never occasionally often

Do you have

Pain or
Cramps? never occasionally often

of days period lasts _____

Days between periods _____

Is your flow

Heavy? 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 review _____ date _____