Health History
(Confidential)

Name _____ Date _____

Age _____ Birthdate _____ Last Physical Examination _____

Reason for visit _____

SYMPTOMS Check symptoms experienced in the past year.

General

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

Gastrointestinal

- ☐ Appetitie poor
- ☐ Bloatint/Gas
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ (check here if vomiting blood)

Muscle/Joint/Bone

Pain, weakness, numness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

Genito-Urinary

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

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
- ☐ Vision - Flashes
- ☐ Vision - Halos

Skin

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

Men (only)

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

Women (only)

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram?

- ☐ Yes
- ☐ No

Are you pregnant?

- ☐ Yes
- ☐ Number of children
- ☐ No

CONDITIONS Check medical conditions you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Anxiety
- ☐ Appendicitis
- ☐ Arthiritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostrate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking.

Name	Dosage	Frequency

Pharmacy Name _____

ALLERGIES to medications or substances

Phone _____

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Medical Problems
Father				
Mother				
Brothers				
Sisters				

Check if blood relatives had any of the following:

Disease	Relationship to patient
☐ Arthiritis, Gout	
☐ Asthma, Hay Fever	
☐ Cancer	
☐ Chemical Dependency	
☐ Diabetes	
☐ Heart Disease, Strokes	
☐ High Blood Pressure	
☐ Kidney Disease	
☐ Tuberculosis	
☐ Other	

HOSPITALIZATIONS AND SURGERIES

Year	Hospital	Reason for Hospitialization and Outcome

PREGNANCY HISTORY

Date	Complication if any

Have you ever had a blood transfusion?

☐ Yes
☐ No

If yes, please give approximate dates

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

HEALTH HABITS

	Frequency
☐ Caffeine	
☐ Tobacco	
☐ Drugs	
☐ Alcohol	
☐ Exercise	
☐ Other	

OCCUPATIONAL CONCERNS

☐ Stress
☐ Hazardous Substance
☐ Heavy Lifting
☐ Other

Your occupation:

SOCIAL HISTORY

Household Members
Children
Birth Control

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

Signature

Date

Reviewed by

Date