HEALTH HISTORY

PATIENT NAME____________________________________ BIRTHDATE____/____/____ PATIENT #_________

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 (foods, drugs, environment)___________________________________
____
____
____

When was your last physical exam?________________
Name of doctor_______________Phone____________
Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred:
____
____
____
____
____

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

Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred):
____
____
____

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)

Condition			Condition			Condition		
Measles	no	yes	Heart Disease	no	yes	Diabetes	no	yes
Mumps	no	yes	Arthritis	no	yes	Cancer	no	yes
Chickenpox	no	yes	Venereal Disease	no	yes	Polio	no	yes
Whooping Cough	no	yes	Anemia	no	yes	Glaucoma	no	yes
Scarlet Fever	no	yes	Bladder Infections	no	yes	Hernia	no	yes
Diptheria	no	yes	Epilepsy	no	yes	Blood or Plasma Transfusions	no	yes
Smallpox	no	yes	Migraine Headaches	no	yes	Back trouble	no	yes
Pneumonia	no	yes	Tuberculosis	no	yes	High/low Blood Pressure	no	yes
Rheumatic Fever	no	yes				Hemorrhoids	no	yes

PAST MEDICAL HISTORY cont.

Date of last Chest x-ray ________________

Condition		
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
Cancer	no	yes________________________
Tuberculosis	no	yes________________________
Diabetes	no	yes________________________
Heart disease	no	yes________________________
High blood Pressure	no	yes________________________
Stroke	no	yes________________________
Epilepsy	no	yes________________________
Allergies	no	yes________________________
Anemia	no	yes________________________
Bleeding Tendency	no	yes________________________
Asthma	no	yes________________________
Chronic Lung Disease	no	yes________________________
Drug/Alcohol Problem	no	yes________________________
Depression	no	yes________________________
Psychosis	no	yes________________________
Suicide	no	yes________________________
Leukemia	no	yes________________________
Migraine Headaches	no	yes________________________
Obesity	no	yes________________________
Thyroid Disease	no	yes________________________
Ulcer	no	yes________________________
High Cholesterol	no	yes________________________
Kidney Disease	no	yes________________________
Glaucoma	no	yes________________________
Gout	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. If deceased, list the cause of death.

Father____

Mother____

Brother____

____

____

Sister____

____

____

Spouse____

Son____

____

____

Daughter_______________________________________

____

____

MEDICAL HISTORY cont.

Do you have now or have you had within the past year:
(Please circle the correct response beside each question)

Condition	Response
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

Condition	Response
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

Condition	Response
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:

Condition	Response
Discharge from Penis	never occasionally often
Pain or lump In testicles	never occasionally often
Impotence	never occasionally often

Women only:

Age period began____________
# of days period lasts_________
Days between periods_________

MEDICAL HISTORY cont.

Is your flow
Heavy? never occasionally often

Do you bleed
Or spot between
periods never occasionally often

Do you have
Pain or
Cramps? 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's comment

Physician's Signature____