



# Health History Form

Patient Name: \_\_\_\_\_ Gender:  Male  Female Today's Date: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Attending Physician: \_\_\_\_\_

What is your reason for visit?: \_\_\_\_\_

**SYMPTOMS – Check symptoms you currently have or have had in the past year**

<p><b>GENERAL</b></p> <p><input type="checkbox"/> Chills  <input type="checkbox"/> Depression  <input type="checkbox"/> Dizziness  <input type="checkbox"/> Fainting  <input type="checkbox"/> Fever  <input type="checkbox"/> Forgetfulness  <input type="checkbox"/> Headache  <input type="checkbox"/> Loss of Sleep  <input type="checkbox"/> Loss of Weight  <input type="checkbox"/> Nervousness  <input type="checkbox"/> Numbness  <input type="checkbox"/> Sweats</p> <p><b>MUSCLE/JOINT/BONE</b>  Pain, weakness, numbness in:  <input type="checkbox"/> Arms  <input type="checkbox"/> Back  <input type="checkbox"/> Feet  <input type="checkbox"/> Hands  <input type="checkbox"/> Hips  <input type="checkbox"/> Legs  <input type="checkbox"/> Neck  <input type="checkbox"/> Shoulders</p> <p><b>GENTO-URINARY</b></p> <p><input type="checkbox"/> Blood in urine  <input type="checkbox"/> Frequent urination  <input type="checkbox"/> Painful urination  <input type="checkbox"/> Lack of bladder control</p>	<p><b>GASTROINTESTINAL</b></p> <p><input type="checkbox"/> Decreased appetite  <input type="checkbox"/> Bloating  <input type="checkbox"/> Bowel changes  <input type="checkbox"/> Constipation  <input type="checkbox"/> Diarrhea  <input type="checkbox"/> Excessive hunger  <input type="checkbox"/> Excessive thirst  <input type="checkbox"/> Gas  <input type="checkbox"/> Hemorrhoids  <input type="checkbox"/> Indigestion  <input type="checkbox"/> Nausea  <input type="checkbox"/> Rectal bleeding  <input type="checkbox"/> Stomach pain  <input type="checkbox"/> Vomiting  <input type="checkbox"/> Vomiting Blood</p> <p><b>CARDIOVASCULAR</b></p> <p><input type="checkbox"/> Chest pain  <input type="checkbox"/> High blood pressure  <input type="checkbox"/> Irregular heart beat  <input type="checkbox"/> Low blood pressure  <input type="checkbox"/> Poor circulation  <input type="checkbox"/> Rapid heart beat  <input type="checkbox"/> Swelling of ankles  <input type="checkbox"/> Varicose veins</p>	<p><b>EYE, EAR, NOSE, THROAT</b></p> <p><input type="checkbox"/> Bleeding gums  <input type="checkbox"/> Blurred vision  <input type="checkbox"/> Crossed eyes  <input type="checkbox"/> Difficultly swallowing  <input type="checkbox"/> Double Vision  <input type="checkbox"/> Earache  <input type="checkbox"/> Ear discharge  <input type="checkbox"/> Hay fever  <input type="checkbox"/> Hoarseness  <input type="checkbox"/> Loss of hearing  <input type="checkbox"/> Nosebleeds  <input type="checkbox"/> Persistent cough  <input type="checkbox"/> Ringing in ears  <input type="checkbox"/> Sinus problems  <input type="checkbox"/> Vision – flashes  <input type="checkbox"/> Vision – halos</p> <p><b>SKIN</b></p> <p><input type="checkbox"/> Bruise easily  <input type="checkbox"/> Hives  <input type="checkbox"/> Itching  <input type="checkbox"/> Change in moles  <input type="checkbox"/> Rash  <input type="checkbox"/> Scars  <input type="checkbox"/> Sores that won't heal</p>	<p><b>MEN only</b></p> <p><input type="checkbox"/> Breast lump  <input type="checkbox"/> Erection difficulties  <input type="checkbox"/> Lump in testicles  <input type="checkbox"/> Penis discharge  <input type="checkbox"/> Sore on penis  <input type="checkbox"/> Other</p> <p><b>WOMEN only</b></p> <p><input type="checkbox"/> Abnormal pap smear  <input type="checkbox"/> Bleeding between periods  <input type="checkbox"/> Breast lump  <input type="checkbox"/> Extreme menstrual pain  <input type="checkbox"/> Hot flashes  <input type="checkbox"/> Nipple discharge  <input type="checkbox"/> Painful intercourse  <input type="checkbox"/> Vaginal discharge  <input type="checkbox"/> Other</p> <p>Date of last menstrual period _____  Date of last Pap Smear _____  Have you had a mammogram? _____  Are you pregnant? _____  Number of children _____</p>
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**CONDITIONS – Check conditions you have has in the past**

<p><input type="checkbox"/> AIDS  <input type="checkbox"/> Alcoholism  <input type="checkbox"/> Anemia  <input type="checkbox"/> Anorexia  <input type="checkbox"/> Appendicitis  <input type="checkbox"/> Arthritis  <input type="checkbox"/> Asthma  <input type="checkbox"/> Bleeding disorders  <input type="checkbox"/> Breast lumps  <input type="checkbox"/> Bronchitis  <input type="checkbox"/> Bulimia  <input type="checkbox"/> Cancer  <input type="checkbox"/> Cataracts</p>	<p><input type="checkbox"/> Chemical dependency  <input type="checkbox"/> Chicken Pox  <input type="checkbox"/> Diabetes  <input type="checkbox"/> Emphysema  <input type="checkbox"/> Epilepsy  <input type="checkbox"/> Glaucoma  <input type="checkbox"/> Goiter  <input type="checkbox"/> Gonorrhea  <input type="checkbox"/> Gout  <input type="checkbox"/> Heart Disease  <input type="checkbox"/> Hepatitis  <input type="checkbox"/> Hernia  <input type="checkbox"/> Herpes</p>	<p><input type="checkbox"/> High Cholesterol  <input type="checkbox"/> HIV Positive  <input type="checkbox"/> Kidney Disease  <input type="checkbox"/> Live Disease  <input type="checkbox"/> Measles  <input type="checkbox"/> Migraine Headaches  <input type="checkbox"/> Miscarriage  <input type="checkbox"/> Mononucleosis  <input type="checkbox"/> Multiple Sclerosis  <input type="checkbox"/> Mumps  <input type="checkbox"/> Pacemaker  <input type="checkbox"/> Pneumonia  <input type="checkbox"/> Polio</p>	<p><input type="checkbox"/> Prostate Problem  <input type="checkbox"/> Psychiatric Care  <input type="checkbox"/> Rheumatic Fever  <input type="checkbox"/> Scarlet Fever  <input type="checkbox"/> Stroke  <input type="checkbox"/> Suicide Attempt  <input type="checkbox"/> Thyroid Problems  <input type="checkbox"/> Tonsillitis  <input type="checkbox"/> Tuberculosis  <input type="checkbox"/> Typhoid Fever  <input type="checkbox"/> Ulcers  <input type="checkbox"/> Vaginal Infections  <input type="checkbox"/> Venereal Disease</p>
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**MEDICATIONS - List medications you are currently taking**      **ALLERGIES To medications or substances**

Pharmacy Name	Phone#

**HERBS/SUPPLEMENTS List any herbs or supplements you are currently taking**

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**- PAST HISTORY – Give names and dates**

<b>Previous Surgery</b>	
<b>Previous Hospitalizations, Major Illnesses Or Injuries</b>	

**- FAMILY HISTORY -**

	Age if Living	Age at Death	Medical conditions or cause of death	Check if any relatives have had:	Relationship to You:
<b>Father</b>				<input type="checkbox"/> Arthritis/Gout <input type="checkbox"/> Asthma/Hay Fever <input type="checkbox"/> Cancer <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease/Heart Attack <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Mental Illness/Suicide <input type="checkbox"/> Thyroid Trouble <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Stroke <input type="checkbox"/> Other	
<b>Mother</b>					
<b>Brothers</b>  Number: _____					
<b>Sisters</b>  Number: _____					
<b>Children</b>  Number: _____					

**Number Living in Household:** \_\_\_\_\_

**- PERSONAL -**

	Smoking	Exercise
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed  Any History of Sexual Abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No Physical Abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Packs per day: _____ Number Years: _____ Year Quit: _____ Type: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Cigar <input type="checkbox"/> Chew  Do You Have an Interest in Quitting? <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount: <input type="checkbox"/> Sedentary <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy  Describe Activites: Weight gain in last year? <input type="checkbox"/> Yes <input type="checkbox"/> No Weight loss in last year? <input type="checkbox"/> Yes <input type="checkbox"/> No Amount: _____
<b>Work</b> Occupation: _____ Company: _____  Does your work expose you to: <input type="checkbox"/> Stress <input type="checkbox"/> Noise <input type="checkbox"/> Heavy <input type="checkbox"/> Hazardous Lifting           Materials <input type="checkbox"/> Other	Coffee – cups/day _____ Aspirin – pills/day _____ Street Drugs used: _____ Have you ever used Injection Drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had a Blood Injection? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please give date: _____	<b>Alcohol</b> Usage: <input type="checkbox"/> Never <input type="checkbox"/> Moderate <input type="checkbox"/> Rare <input type="checkbox"/> Heavy  Alcohol Problem? <input type="checkbox"/> Yes <input type="checkbox"/> No

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change of health.

Signature of patient, parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

Printed name or patient, parent or guardian \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Reviewed by (Clinician) \_\_\_\_\_ Date \_\_\_\_\_