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

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

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

GENITO-URINARY

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

GASTROINTESTINAL

- ☐ Decreased appetite
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting Blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficultly 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
- ☐ Sores 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?__________

Are you pregnant?_______

Number of children______

CONDITIONS – Check conditions you have has in the past

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lumps
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Live Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

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

- PAST HISTORY – Give names and dates

Previous Surgery	
Previous Hospitalizations, Major Illnesses Or Injuries	

- FAMILY HISTORY -

	Age if Living	Age at Death	Medical conditions or cause of death
Father			
Mother			
Brothers			
Number:_____			
Sisters			
Number:_____			
Children			
Number:_____			

Check if any relatives have had: | **Relationship to You:**

- ☐ Arthritis/Gout
- ☐ Asthma/Hay Fever
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Heart Disease/Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Mental Illness/Suicide
- ☐ Thyroid Trouble
- ☐ Tuberculosis
- ☐ Stroke
- ☐ Other

Number Living in Household:

- PERSONAL -

Marital Status: ☐ Married ☐ Divorced ☐Single ☐ Widowed

Any History of Sexual Abuse? ☐ Yes ☐ No

Physical Abuse? ☐ Yes ☐ No

Work

Occupation: ____________

Company: ____________

Does your work expose you to: ☐ Stress ☐ Noise ☐Heavy Lifting ☐ Hazardous Materials ☐ Other

Smoking

Packs per day: ____________

Number Years: ____________

Year Quit: ____________

Type: ☐ Cigarettes ☐ Pipe ☐ Cigar ☐ Chew

Do You Have an Interest in Quitting? ☐ Yes ☐ No

Coffee – cups/day ____________

Aspirin – pills/day ____________

Street Drugs used: ____________

Have you ever used Injection Drugs? ☐ Yes ☐ No ☐ Yes ☐ No

Have you ever had a Blood Injection? ☐ Yes ☐ No

If so, please give date:

Exercise

Amount: ☐ Sedentary ☐ Mild ☐Moderate ☐ Heavy

Describe Activites:

Weight gain in last year? ☐ Yes ☐ No

Weight loss in last year? ☐ Yes ☐ No

Amount:

Alcohol

Usage: ☐ Never ☐ Moderate ☐ Rare ☐ Heavy

Alcohol Problem? ☐ Yes ☐ 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