HEALTH HISTORY
(Confidential)

Name______________________________ Today's Date______________

Age__________ Birthdate______________ Date of last physical examination______________________

What is your reason for visit?____

Conditions: Check (√) conditions you have presently.

GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	MEN ONLY
Chills	Appetite Poor	Bleeding Gums	Breast Lump
Depression	Bloating	Blurred Vision	Erection Difficulties
Fainting	Bowel Changes	Crossed Eyes	Lump In Testicles
Fever	Constipation	Difficulty Swallowing	Penis Discharge
Forgetfulness	Diarrhea	Double Vision	Sore On Penis
Headache	Excessive Hunger	Earache	Other
Loss Of Sleep	Excessive Thirst	Hay Fever	
Loss Of Weight	Gas	Hoarseness	**WOMEN ONLY**
Nervousness	Hemorrhoids	Loss Of Hearing	Abnormal Pap Smear
Numbness	Indigestion	Nosebleeds	Bleeding Between Periods
Sweats	Nausea	Persistent Cough	Breast Lump
MUSCLE/JOINT/BONE	Rectal Bleeding	Ringing In Ears	Extreme Menstrual Pain
Pain, Weakness, Numbness in:	Stomach Pain	Sinus Problems	Hot Flashes
Arms Hips	Vomiting	Vision-Flashes	Nipple Discharge
Back Legs	Vomiting Blood	Vision-Halos	Painful Intercourse
Feet Neck	**CARDIOVASCULAR**	**SKIN**	Other
Shoulders	Chest Pain	Bruise Easily	Date of Last Menstrual
GENITO-URINARY	High Blood Pressure	Hives	Period ____________
Blood in Urine	Irregular Heart Beat	Itching	Date of Last Pap Smear
Frequent Urination	Low Blood Pressure	Change in Moles	__________. Have You
Lack of Bladder Control	Poor Circulation	Rash	Had a Mammogram?_____
Painful Urination	Rapid Heart Beat	Scars	Are You Pregnant?_____
	Swelling of Ankles	Sore That Won't Heal	Number of Children?_____
	Varicose Veins		

CONDITIONS Check (√) conditions you have had in the past.

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

MEDICATIONS List medications you are currently taking	ALLERGIES To medications or substances
Pharmacy Name Phone #:	

(All information is strictly confidential)

FAMILY HISTORY (Fill in information about your family)

Relation	Age	State of Health	Cause of Death		Check (√) if, your blood relatives had any of the following: Disease	Relationship To You
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

Hospitalization

Year	Hospital	Reason For Hospitalization/Outcome

Have you ever had a blood transfusion? Yes No

If yes, please give approximate dates:

SERIOUS ILLNESSES/INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Year Birth	Sex Birth	Complications if any

HEALTH HABITS Check (√) which substances you use and describe how much you use.

	Substance	
	Caffeine	
	Tobacco	
	Drugs	
	Other	

OCCUPATIONAL CONCERNS: Check (√) if your work exposes you to the following:

	Exposure
	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your Occupation:

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

Signature _______________ Date _______________

Reviewed by _______________ Date _______________