HEALTH HISTORY Confidential

Patient Name		Today's [Today's Date			
Age Birthdate	Date of last phy	Date of last physical examination				
What is your reason for visit?						
SYMPTOMS Check (✓) sym	ptoms you currently have or have	had in the past year.				
GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	MEN only			
☐ Chills	☐ Appetite poor	☐ Bleeding gums	☐ Breast lump			
☐ Depression	☐ Bloating	☐ Blurred vision	☐ Erection difficulties			
Dizziness	☐ Bowel changes	☐ Crossed eyes	☐ Lump in testicles			
☐ Fainting	☐ Constipation	☐ Difficulty swallowing	☐ Penis discharge			
Fever	Diarrhea	☐ Double vision	☐ Sore on penis			
Forgetfulness	☐ Excessive hunger	☐ Earache	Other			
☐ Headache	☐ Excessive thirst	☐ Ear discharge				
Loss of sleep	☐ Gas	☐ Hay fever	WOMEN only			
Loss of weight	☐ Hemorrhoids	☐ Hoarseness	☐ Abnormal Pap Smear			
Nervousness	☐ Indigestion	Loss of hearing	☐ Bleeding between periods			
Numbness	☐ Nausea	☐ Nosebleeds	☐ Breast lump			
Sweats	☐ Rectal bleeding	Persistent cough	☐ Extreme menstrual pain			
GWEats	☐ Stomach pain	☐ Ringing in ears	☐ Hot flashes			
MUSCLE/JOINT/BONE	☐ Vomiting	☐ Sinus problems	☐ Nipple discharge			
	☐ Vomiting blood	☐ Vision – Flashes	☐ Painful intercourse			
Pain, weakness, numbness in:	□ vomiting blood		☐ Vaginal discharge			
☐ Arms ☐ Hips	CARDIOVASCULAR	☐ Vision – Halos	☐ Other			
☐ Back ☐ Legs		CKIN	Date of last			
☐ Feet ☐ Neck	☐ Chest pain	SKIN	menstrual period			
☐ Hands ☐ Shoulders	☐ High blood pressure	☐ Bruise easily	Date of last			
OFFICE LIBITIA BY	☐ Irregular heart beat	Hives	Pap Smear			
GENITO-URINARY	Low blood pressure	☐ Itching	•			
☐ Blood in urine	☐ Poor circulation	☐ Change in moles	Have you had			
☐ Frequent urination	☐ Rapid heart beat	Rash	a mammogram?			
Lack of bladder control	Swelling of ankles	Scars	Are you pregnant?			
☐ Painful urination	☐ Varicose veins	☐ Sore that won't heal	Number of children			
CONDITIONS Check (✓) con	nditions you have or 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			
Anorexia	☐ Emphysema	☐ Liver Disease	☐ Scarlet Fever			
☐ Appendicitis	☐ Epilepsy	☐ Measles	Stroke			
☐ Arthritis	☐ Glaucoma	☐ Migraine Headaches	☐ Suicide Attempt			
☐ Asthma	Goiter	☐ Miscarriage	☐ Thyroid Problems			
☐ Bleeding Disorders	☐ Gonorrhea	☐ Mononucleosis	☐ Tonsillitis			
☐ Breast Lump	Gout	☐ Multiple Sclerosis	☐ Tuberculosis			
☐ Bronchitis	☐ Heart Disease	☐ Mumps	☐ Typhoid Fever			
☐ Bulimia	☐ Hepatitis	☐ Pacemaker	Ulcers			
☐ Cancer	☐ Hernia	☐ Pneumonia	☐ Vaginal Infections			
☐ Cataracts	Herpes	Polio	☐ Venereal Disease			
	'					
MEDICATIONS List medicat	tions you are currently taking.	ALLERGIES To	ALLERGIES To medications or substances			
			3			
Pharmacy Name	Phone					

All information is strictly confidential

Relation	Age	State of Health	Age at Death	Cause of Death	Check		ood rel sease	atives had	any of the following: Relationship to you
Father						Arthritis, Gout			
Mother						Asthma, Hay Fever			
rothers						Cancer	cer		
						Chemical De	Pependency		
						Diabetes			
						Heart Diseas	se, Stro	kes	
Sisters						High Blood F	Pressure	е	
						Kidney Disea			
						Tuberculosis			
						Other			
HOSPITALIZATIONS Year Hospital		Reason for Hosp	ospitalization and Outcome		PREGNANCY Year of Sex of Birth Service		HISTORY Complications if any		
							subst	ances you i you use.	TS Check (✓) which use and describe how
								Caffeine	
Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, please give approximate dates				☐ No			Tobacco		
					Street Drugs		igs		
SERIOUS ILLNESS/INJURIES			DATE	OUTO	OME		Other		
							Chec		AL CONCERNS work exposes you to
								Stress	
								Hazardous	s Substances
								Heavy Lift	ing
							Other		
							Your	occupation:	
the best of m	ny knowl	edge, the abo	ve information	is complete and correct. I u	inderstand that it i	s my responsibilit	y to inforn	n my doctor if I,	or my minor child, ever have a
		ature of Poti-	nt Parant C	rdian or Paragnal Dans	ntativo				Date
	Sign	ature of Falle	in, Falent, Gua	rdian or Personal Represe	illalive				Date
F	Please p	rint name of F	Patient, Parent,	Guardian or Personal Repr	resentative			Relatio	nship to Patient
			Pavio	ved Bv					Date