

# ⌘ Health History ⌘

Patient Name		Today's Date	
Age	Birthdate	Date of last physical examination	
What is your reason for this visit?			

## ⌘ Symptoms ⌘

*Check (✓) conditions you currently have or have had in the past year.*

GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	MEN ONLY
<input type="checkbox"/> Chills	<input type="checkbox"/> Appetite poor	<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Breast lump
<input type="checkbox"/> Depression	<input type="checkbox"/> Bloating	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Erection difficulties
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Bowel changes	<input type="checkbox"/> Crossed eyes	<input type="checkbox"/> Lump in testicles
<input type="checkbox"/> Fainting	<input type="checkbox"/> Constipation	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Penis discharge
<input type="checkbox"/> Fever	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Double vision	<input type="checkbox"/> Sore on penis
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Earache	<input type="checkbox"/> Other
<input type="checkbox"/> Headache	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Ear discharge	<b>WOMEN ONLY</b>
<input type="checkbox"/> Loss of sleep	<input type="checkbox"/> Gas	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Abnormal Pap Smear
<input type="checkbox"/> Loss of weight	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Bleeding between periods
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Breast lump
<input type="checkbox"/> Numbness	<input type="checkbox"/> Nausea	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Extreme menstrual pain
<input type="checkbox"/> Sweats	<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Hot flashes
	<input type="checkbox"/> Stomach pain	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Nipple discharge
	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Painful intercourse
	<input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Vision – Flashes	<input type="checkbox"/> Vaginal discharge
<b>MUSCLE/JOINT/BONE</b>			<input type="checkbox"/> Other
Pain, weakness, numbness in:			
<input type="checkbox"/> Arms	<input type="checkbox"/> Hips		Date of last Menstrual period _____
<input type="checkbox"/> Back	<input type="checkbox"/> Legs	<b>CARDIOVASCULAR</b>	Date of last Pap Smear _____
<input type="checkbox"/> Feet	<input type="checkbox"/> Neck	<input type="checkbox"/> Chest Pain	Have you had a mammogram? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Hands	<input type="checkbox"/> Shoulders	<input type="checkbox"/> High blood pressure	Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Irregular heart beat	Number of children _____
<b>GENITO-URINARY</b>		<input type="checkbox"/> Low blood pressure	
<input type="checkbox"/> Blood in urine		<input type="checkbox"/> Poor circulation	
<input type="checkbox"/> Frequent urination		<input type="checkbox"/> Rapid heart beat	
<input type="checkbox"/> Lack of bladder control		<input type="checkbox"/> Swelling of ankles	
<input type="checkbox"/> Painful urination		<input type="checkbox"/> Varicose veins	
		<b>SKIN</b>	
		<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"/> Sore that won't heal	

## ⌘ Conditions ⌘

*Check (✓) conditions you currently have or have had in the past year.*

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

### ⌘ Medications ⌘ List medications you are currently taking.

Pharmacy Name: _____	Phone: _____

### ⌘ Allergies ⌘


**Fill in health information about your family**

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following:	
					Disease	Relationship to you
Father					<input type="checkbox"/>	Arthritis, Gout
Mother					<input type="checkbox"/>	Asthma, Hay Fever
Brothers					<input type="checkbox"/>	Cancer
					<input type="checkbox"/>	Chemical Dependency
					<input type="checkbox"/>	Diabetes
					<input type="checkbox"/>	Heart Disease, Strokes
Sisters					<input type="checkbox"/>	High Blood Pressure
					<input type="checkbox"/>	Kidney Disease
					<input type="checkbox"/>	Tuberculosis
					<input type="checkbox"/>	Other

**ඞ Hospitalizations ඞ**

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion?       Yes  No

If yes, please give approx. dates \_\_\_\_\_

**ඞ Pregnancies ඞ**

Year of Birth	Sex of Birth	Complications if any

**ඞ Health Habits ඞ**

Check (✓) which substances you use and describe how much you use.

<input type="checkbox"/>	Caffeine	
<input type="checkbox"/>	Tobacco	
<input type="checkbox"/>	Drugs	
<input type="checkbox"/>	Other	

**ඞ Occupational ඞ**

Check (✓) if your work exposes you to the Following:

<input type="checkbox"/>	Stress	<input type="checkbox"/>	Hazardous Substance
<input type="checkbox"/>	Heavy Lifting	<input type="checkbox"/>	Other
Occupation			

Serious Illness/Injuries	Date	Outcome

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