

HEALTH HISTORY

Adult

Name _____ Date _____

Age _____ Birth Date ____/____/____ Last Physical Exam ____/____/____

FOR ESTABLISHED PATIENTS, ONLY THE FRONT SIDE NEEDS TO BE COMPLETED.

SYMPTOMS Circle all symptoms you currently have or have had in the last year ---

GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	MEN ONLY
Chills Depression Dizziness Fainting Fever Forgetfulness Headache Loss of sleep Nervousness Numbness Shortness of breath Sweats	Poor Appetite Bloating Bowel Changes Constipation Diarrhea Excessive Hunger Excessive Thirst Gas Hemorrhoids Indigestion Rectal Bleeding Stomach Pain Vomiting Vomiting Blood	Bleeding Gums Blurred Vision Crossed Eyes Difficulty Swallowing Double Vision Earache Ear Discharge Hay Fever (allergies) Hoarseness Loss of hearing Nosebleeds Persistent Cough Ringing in ears Sinus Problems Vision-Flashes/Halos	Breast Lump Erection Problems Lump in Testes Penile Discharge Sore on Penis Other _____
			WOMEN ONLY
MUSCLE/JOINT/BONE Pain/Weakness/Numbness			Abnormal Pap Smear Bleeding between periods Breast Lump Extreme Menstrual Pain Hot Flashes Nipple Discharge Painful Intercourse Vaginal Discharge Last Period _____ Last Pap _____ Mammogram _____ Pregnant?? _____ # of Children _____ Other _____
		CARDIOVASCULAR	
Arms Hips Back Legs Feet Neck Hands Shoulders	Chest Pain High Blood Pressure Irregular Heart Beat Low Blood Pressure Poor Circulation Rapid Heart Beat Swelling of Ankles Varicose Veins	SKIN	
GENITO-URINARY		Easy Bruising Hives Itching Change in Moles Rash Scars Sores that don't heal	
Blood in Urine Frequent Urination Lack of Bladder Control Painful Urination			

CONDITIONS Circle all that you have or have had in the past

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

MEDICATIONS List name / dose / frequency	ALLERGIES	IMMUNIZATIONS Year

PHYSICIAN NOTES:

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age of Death	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, Stroke	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS			PREGNANCY HISTORY		
Yr.	Hospital	Reason for Hospitalization and Outcome	Yr of Birth	Sex of Birth	Complications, if any.

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

	Caffeine	
	Tobacco	
	Drugs	
	Other	

Have you ever had a blood transfusion? Yes No
 If yes, please give approximate date: _____

SERIOUS ILLNESS / INJURIES	DATE	OUTCOME

OTHER DOCTORS YOU SEE

Name:	Reason:

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

	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