**Health History (confidential)**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age:\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last physical exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your reason for today’s visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SYMPTOMS: (circle current symptoms)**

|  |  |  |  |
| --- | --- | --- | --- |
| General:ChillsDepressionDizzinessFaintingFeverForgetfulnessHeadacheLoss of SleepLoss Of WeightNervousnessNumbnessSweatsMuscle/Joint or Bone:Pain, weakness, numbness in: arms hips back legs feet neck hands shouldersGenito-Urinary:Blood in UrineFrequent UrinationLack of Bladder ControlPainful Urination | Gastrointestinal:Poor AppetiteBloatingBowel ChangesConstipationDiarrheaGasHemorrhoidsNausea/VomitingRectal BleedingStomach PainSkin:Bruise easilyItchingRashSore that won’t heal Change in MolesCardio Vascular:Chest PainHigh Blood PressureLow Blood PressureIrregular Heart BeatPoor CirculationSwelling of AnklesVaricose Veins | Eyes, Ears, Nose, Throat:Bleeding GumsBlurred VisionDifficulty swallowingDouble VisionEaracheEar DischargeHay FeverHoarsenessLoss of HearingNosebleedsPersistent CoughRinging in ears Sinus ProblemsVision-Flashes/HalosMen Only:Breast LumpErection DifficultiesLump in TesticlesPenis DischargeSore on PenisDate of last Colonoscopy:\_\_\_\_\_\_\_\_\_\_\_OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Women Only:Abnormal Pap SmearBleeding Between PeriodsBreast LumpExtreme Menstrual PainHot FlashesNipple DischargePainful IntercourseVaginal DischargeDate of Last Period:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Last Pap:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Last Mammo:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pregnant: Yes No # of Pregnancies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pregnancy Complications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_# of Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Last Colonoscopy:\_\_\_\_\_\_\_\_\_\_\_OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**CONDITIONS: (circle conditions you currently have or have had)**

|  |  |  |  |
| --- | --- | --- | --- |
| Acid RefluxAIDSAlcoholismAllergiesAnemiaAneurysmAnorexiaArthritisAsthmaBleeding DisordersBulimiaCancerCataracts | Chemical DependencyChicken PoxDiabetesEmphysema/COPDEpilepsyGlaucomaGoiterGonorrhea/ChlamydiaGoutHeart DiseaseHepatitis A B CHerniaHerpes | High CholesterolHIV HypertensionKidney DiseaseLiver DiseaseMeaslesMigraine HeadachesMononucleosisMumpsMultiple SclerosisPacemakerPneumoniaPolio | Prostate ProblemPsychiatric CareScarlet FeverShinglesSleep DisorderStrokeSuicide AttemptThyroid ProblemsTuberculosisUlcersVaginal InfectionsVenereal Disease/STDOther:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Pharmacy & Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Phone:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

|  |  |
| --- | --- |
| **Medications:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Drug Allergies/Reaction:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Family History: (Fill in health information about your family)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Relation** | **Age**  | **Health Problems** | **Cause of Death** | **Check if your blood relative had any of the following:** **Disease : Relation to You** |
| **Father** |  |  |  | **Asthma, Hay Fever** |
| **Mother** |  |  |  | **Cancer (type)** |
| **Brothers** |  |  |  | **Chemical Dependency** |
|  |  |  |  | **Diabetes (type)** |
|  |  |  |  | **Heart Disease, Strokes** |
| **Sisters** |  |  |  | **Kidney Disease** |
|  |  |  |  | **Tuberculosis** |
|  |  |  |  | **Other:** |

**Hospitalizations/Surgeries:**

|  |  |  |
| --- | --- | --- |
| **Year** | **Hospital** | **Reason for Hospitalization & Outcome** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Have you ever had a blood transfusion?** Yes No

If yes, please give approximate date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Habits: (check which substances you use & describe how much you use)**

|  |  |  |
| --- | --- | --- |
|  | **Caffeine** |  |
|   | **Tobacco** |  |
|  | **Street Drugs** |  |
|  | **Alcohol** |  |

**Occupational: (check if your work exposes you to the following)**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Stress** |  | **Hazardous Substances** |
|  | **Heavy Lifting** |  | **Other:\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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**