**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:  Chills  Depression  Dizziness  Fainting  Fever  Forgetfulness  Headache  Loss of Sleep  Loss Of Weight  Nervousness  Numbness  Sweats  Muscle/Joint or Bone:  Pain, weakness, numbness in:  arms hips back legs feet neck hands shoulders  Genito-Urinary:  Blood in Urine  Frequent Urination  Lack of Bladder Control  Painful Urination | Gastrointestinal:  Poor Appetite  Bloating  Bowel Changes  Constipation  Diarrhea  Gas  Hemorrhoids  Nausea/Vomiting  Rectal Bleeding  Stomach Pain  Skin:  Bruise easily  Itching  Rash  Sore that won’t heal  Change in Moles  Cardio Vascular:  Chest Pain  High Blood Pressure  Low Blood Pressure  Irregular Heart Beat  Poor Circulation  Swelling of Ankles  Varicose Veins | Eyes, Ears, Nose, Throat:  Bleeding Gums  Blurred Vision  Difficulty swallowing  Double Vision  Earache  Ear Discharge  Hay Fever  Hoarseness  Loss of Hearing  Nosebleeds  Persistent Cough  Ringing in ears  Sinus Problems  Vision-Flashes/Halos  Men Only:  Breast Lump  Erection Difficulties  Lump in Testicles  Penis Discharge  Sore on Penis  Date of last Colonoscopy:\_\_\_\_\_\_\_\_\_\_\_  OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Women Only:  Abnormal Pap Smear  Bleeding Between Periods  Breast Lump  Extreme Menstrual Pain  Hot Flashes  Nipple Discharge  Painful Intercourse  Vaginal Discharge  Date 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 Reflux  AIDS  Alcoholism  Allergies  Anemia  Aneurysm  Anorexia  Arthritis  Asthma  Bleeding Disorders  Bulimia  Cancer  Cataracts | Chemical Dependency  Chicken Pox  Diabetes  Emphysema/COPD  Epilepsy  Glaucoma  Goiter  Gonorrhea/Chlamydia  Gout  Heart Disease  Hepatitis A B C  Hernia  Herpes | High Cholesterol  HIV  Hypertension  Kidney Disease  Liver Disease  Measles  Migraine Headaches  Mononucleosis  Mumps  Multiple Sclerosis  Pacemaker  Pneumonia  Polio | Prostate Problem  Psychiatric Care  Scarlet Fever  Shingles  Sleep Disorder  Stroke  Suicide Attempt  Thyroid Problems  Tuberculosis  Ulcers  Vaginal Infections  Venereal Disease/STD  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **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**