HEALTH HISTORY

PATIENT NAME _____ BIRTHDATE ___/___/___ PATIENT # _____

To help us meet all your healthcare needs, please fill out **both sides** of this form completely in ink. This is a confidential record of your medical history and will be kept in this office.

Today's date _____
Place of birth _____
Highest level in school _____
Occupation _____
Previous occupations _____
Marital status _____
Hobbies _____
Exercise/recreation _____
Habits:
Smoking (type & amount per day) _____
If former smoker, date quit _____
Alcohol (type & amount per week) _____
Caffeine (type & amount per day) _____
Street drugs (type & amount per day) _____
Usual weight _____
Date of last dental exam _____
Please list all allergies (foods, drugs, environment)

_____
_____
_____

Have you ever taken Fen-Phen/Redux? _____

When was your last physical exam? _____
Name of doctor _____ Phone _____
Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred: ☐ none

_____
_____
_____
_____

Please list all medicines you are currently taking (include nonprescription drugs): ☐ none

_____
_____
_____

Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred): ☐ none

_____
_____
_____

Chief Complaints
Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

_____
_____

Past Medical History
Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	Migraine headaches	no	yes	Hives or Eczema	no	yes
Mumps	no	yes	Tuberculosis	no	yes	AIDS or HIV+	no	yes
Chickenpox	no	yes	Diabetes	no	yes	Infectious Mono	no	yes
Whooping Cough	no	yes	Cancer	no	yes	Bronchitis	no	yes
Scarlet Fever	no	yes	Polio	no	yes	Mitral Valve Prolapse	no	yes
Diphtheria	no	yes	Glaucoma	no	yes	Stroke	no	yes
Smallpox	no	yes	Hernia	no	yes	Hepatitis	no	yes
Pneumonia	no	yes	Blood or Plasma transfusions	no	yes	Ulcer	no	yes
Rheumatic Fever	no	yes				Kidney Disease	no	yes
Heart Disease	no	yes	Back trouble	no	yes	Thyroid Disease	no	yes
Arthritis	no	yes	High or low blood pressure	no	yes	Bleeding tendency	no	yes
Venereal Disease	no	yes				Any other disease	no	yes
Anemia	no	yes	Hemorrhoids	no	yes	(please list) _____		
Bladder Infections	no	yes	Date of last chest x-ray _____					
Epilepsy	no	yes	Asthma	no	yes			

Family History
Has any blood relative had any of the following: (Circle "no" or "yes", leave blank if uncertain)

			Relationship				Relationship
Cancer	no	yes		Stroke	no	yes	
Tuberculosis	no	yes		Epilepsy	no	yes	
Diabetes	no	yes		Allergies	no	yes	
Heart Disease	no	yes		Anemia	no	yes	
High blood pressure	no	yes		Bleeding tendency	no	yes	

Family History (cont.)
(Circle "no" or "yes", leave blank if uncertain)

			Relationship	Present age, or age of death	If living, health (good, fair, poor) If deceased, cause of death
Asthma	no	yes		Father	
Chronic lung disease	no	yes		Mother	
Drug or alcohol problem	no	yes		Siblings	
Mental Illness	no	yes			
Leukemia	no	yes			
Migraine headaches	no	yes			
Obesity	no	yes			
Thyroid Disease	no	yes		Spouse	
Ulcer	no	yes		Children	
Depression	no	yes			
High Cholesterol	no	yes			
Kidney Disease	no	yes			
Glaucoma	no	yes			
Gout	no	yes			

Do you have now or have you had within the past year: (Circle "no" or "yes", leave blank if uncertain)

Weakness or paralysis	no	yes	Shortness of breath	no	yes	Joint pain or stiffness	no	yes
Tire easily or weakness	no	yes	Bloody sputum	no	yes	Swollen joints	no	yes
Recent weight changes	no	yes	Wheezing	no	yes	Muscle cramps or spasms	no	yes
Change in appetite	no	yes	Chest pain or discomfort	no	yes	Sleeplessness	no	yes
Sensitivity to cold or heat	no	yes	Purple fingers or lips	no	yes	Seizures	no	yes
Persistent fever	no	yes	Swelling of hands, feet or ankles	no	yes	Depression	no	yes
Night sweats or hot flashes	no	yes	Difficulty in breathing	no	yes	Memory loss	no	yes
Skin rash	no	yes	Palpitations or fluttering of the heart	no	yes	Poor coordination	no	yes
Skin trouble or changes	no	yes	Leg cramps on walking or at night	no	yes	Dizziness or fainting spells	no	yes
Change in nails or hair	no	yes	Enlarged veins	no	yes	A living will or advance directive	no	yes
Headaches	no	yes	Difficulty swallowing	no	yes	**Men only:**		
Easy bleeding or bruising	no	yes	Heartburn	no	yes	Discharge from penis	no	yes
Double vision	no	yes	Frequent belching	no	yes	Pain or lump in testicles	no	yes
Blurred vision	no	yes	Abdominal cramping	no	yes	Impotence	no	yes
Eye pain	no	yes	Nausea	no	yes	**Women only:**		
Infected eyes	no	yes	Vomiting	no	yes	Age period began _____		
Do you wear glasses or contacts	no	yes	Vomited or coughed up blood	no	yes	How many days do periods last? _____		
When was your last eye exam_____			Chronic diarrhea	no	yes	How many days between periods? _____		
Ringing in the ears	no	yes	Chronic constipation	no	yes	Is the flow heavy?	no	yes
Discharge from ears	no	yes	Rectal bleeding	no	yes	Do you bleed or spot between periods?	no	yes
Ear pain	no	yes	Black tarry stools	no	yes			
Decrease in hearing	no	yes	Dark urine	no	yes	Do you have pain or cramps?	no	yes
Frequent nosebleeds	no	yes	Yellow jaundice	no	yes	Date of last period? _____		
Frequent colds	no	yes	Frequent urination (day)	no	yes	Date of last pelvic exam? _____		
Sinus trouble	no	yes	Frequent urination (night)	no	yes	Date of last mammogram? _____		
Loss of smell	no	yes	Increase in thirst	no	yes	Any itching in vaginal area?	no	yes
Persistent hoarseness	no	yes	Painful urination	no	yes	Pain with intercourse?	no	yes
Sore throat	no	yes	Leakage of urine	no	yes	Type of birth control used? _____		
Sore tongue or gums	no	yes	Difficulty in starting urine	no	yes	Number of pregnancies _____		
Lump or discharge from breast	no	yes	Blood in urine	no	yes	Number of full term births _____		
A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	no	yes	Lack of sex drive	no	yes	Number of preterm births _____		
			Hemorrhoids	no	yes			
			Backaches	no	yes			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

X _____ _____
Signature of patient or parent if minor Date

Physician's Comment

Physician's Signature _____ _____