

HEALTH HISTORY

PATIENT NAME _____ BIRTHDATE _____ / _____ / _____

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) _____ _____ _____	When was your last physical exam? _____ Name of doctor _____ Phone _____ Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate years these occurred: <input type="checkbox"/> NONE _____ _____ Please list all medications you are currently taking (include non-prescription drugs): <input type="checkbox"/> NONE _____ _____ Describe all serious accidents, severe injuries, head injury, fractures, or broken bones (include date occurred): <input type="checkbox"/> NONE _____ _____ _____
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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 _____	no	yes	Ulcer _____	no	yes
Rheumatic Fever _____	no	yes	transfusions			Kidney Disease _____	no	yes
Heart Disease _____	no	yes	Back trouble _____	no	yes	Thyroid Disease _____	no	yes
Arthritis _____	no	yes	High or low blood _____	no	yes	Bleeding tendency _____	no	yes
Venereal Disease _____	no	yes	pressure			Any other disease _____	no	yes
Bladder Infections _____	no	yes	Date of last chest x-ray _____			(please list) _____		
Anemia _____	no	yes	Hemorrhoids _____	no	yes	_____		
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)

Cancer _____	no	yes	Relationship _____	Stroke _____	no	yes	Relationship _____
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	Bloody Sputum _____	no	yes	Joint pain or stiffness _____	no	yes
Tires easily or weakness _____	no	yes	Wheezing _____	no	yes	Swollen joints _____	no	yes
Recent weight changes _____	no	yes	Chest pain or discomfort _____	no	yes	Muscle cramps or spasms _____	no	yes
Change in appetite _____	no	yes	Purple fingers or lips _____	no	yes	Sleeplessness _____	no	yes
Sensitivity to cold or heat _____	no	yes	Swelling of extremities _____	no	yes	Seizures _____	no	yes
Persistent fever _____	no	yes	Difficulty in breathing _____	no	yes	Depression _____	no	yes
Night sweats or hot flashes _____	no	yes	Palpitations/fluttering heart _____	no	yes	Memory loss _____	no	yes
Skin rash _____	no	yes	Leg cramps on walking _____	no	yes	Poor coordination _____	no	yes
Skin trouble or changes _____	no	yes	Enlarged veins _____	no	yes	Dizziness or fainting spells _____	no	yes
Change in nails or hair _____	no	yes	Difficulty swallowing _____	no	yes	A living will or _____	no	yes
Headaches _____	no	yes	Heartburn _____	no	yes	Advance Directive _____		
Easy bleeding or bruising _____	no	yes	Abdominal cramping _____	no	yes	MEN ONLY:		
Double vision _____	no	yes	Frequent belching _____	no	yes	Discharge from penis _____	no	yes
Blurred vision _____	no	yes	Nausea _____	no	yes	Pain or lump in testicles _____	no	yes
Eye Pain _____	no	yes	Vomiting _____	no	yes	Impotence _____	no	yes
Infected eyes _____	no	yes	Vomited or coughed up blood _____	no	yes	WOMEN ONLY:		
Do you wear glasses or contacts _____	no	yes	Chronic diarrhea _____	no	yes	Age period began _____		
When was your last eye exam _____			Chronic constipation _____	no	yes	How many days do periods last? _____		
Ringing in the ears _____	no	yes	Rectal bleeding _____	no	yes	How many days between periods? _____		
Discharge from ears _____	no	yes	Black tarry stools _____	no	yes	Is the flow heavy? _____	no	yes
Ear pain _____	no	yes	Dark urine _____	no	yes	Do you bleed or spot between _____		
Decrease in hearing _____	no	yes	Yellow jaundice _____	no	yes	between periods _____	no	yes
Frequent nosebleeds _____	no	yes	Frequent urination (day) _____	no	yes	Date of last period? _____		
Frequent colds _____	no	yes	Frequent urination (night) _____	no	yes	Do you have pain or cramps? _____	no	yes
Sinus trouble _____	no	yes	Increase in thirst _____	no	yes	Date of last pelvic exam? _____		
Loss of smell _____	no	yes	Painful urination _____	no	yes	Date of last mammogram? _____		
Persistent hoarseness _____	no	yes	Leakage of urine _____	no	yes	Pain with intercourse? _____	no	yes
Sore throat _____	no	yes	Difficulty in starting urine _____	no	yes	Any itching in vaginal area? _____	no	yes
Sore tongue or gums _____	no	yes	Blood in urine _____	no	yes	Type of birth control used? _____		
Lump or discharge from breast _____	no	yes	Lack of sex drive _____	no	yes	Number of pregnancies _____		
Chronic or frequent cough _____	no	yes	Hemorrhoids _____	no	yes	Number of full term births _____		
Shortness of breath _____	no	yes	Backaches _____	no	yes	Number of preterm births _____		

X _____
Signature of patient or parent if minor

Date