Health History Form

Name:_____ Date of Birth:_____ Today's Date:_____ Sex: M F
Drug Allergies:_____

Past Medical History: Have you ever had the following? (Circle all that apply)

Chronic Headaches	Asthma	Anemia
Depression/Anxiety	Pneumonia	Blood Clots
Eating Disorder	Tuberculosis	Blood Transfusion
Seizures	Emphysema	Infectious Mono
Stroke	Ulcer/Heartburn/Acid Reflux	Venereal Disease/STD
Eye Problems	Irritable Bowel Syndrome	Hepatitis A B C
Hearing Problems	Liver Disease	HIV or AIDS
Allergies/Hay Fever	Kidney Disease	Rheumatic Fever
Chronic Sinus Problems	Bladder Infections	Back Problem
Heart Disease	Bladder Leakage/Incontinence	Arthritis Type:_____
High Blood Pressure	Hernia	Cancer Type:_____
High Cholesterol	Hemorrhoids	Other:_____
Angina	Thyroid Disease	_____
Eczema or Hives	Diabetes Type:_____	_____

Women:

Date of Last Pap_____	Date of Last Mammogram_____	Number of Pregnancies_____
Ever Abnormal Pap_____	Ever Abnormal Mammogram_____	Number of Children_____
Hysterectomy? Yes No	Breast Implants? Yes No	Number of Miscarriages_____

Menstrual Difficulties? (list)_____

Men: Date of last PSA (if over age 40)_____ Erectile Difficulties? Yes No

Previous Hospitalizations/Surgeries/Serious Illnesses:	**Date**	**Hospital, City, State**

Patient Social History:

Marital Status:	Single	Married	Separated	Divorced	Widowed
Use of Alcohol:	Never	Rarely	Moderate	Daily	
Use of Tobacco:	Never	Previously, but quit on:_____		Current packs per day:_____	
Use of Drugs:	Never	Type_____		Frequency_____	
Occupation:_____		Exposure to: Fumes_____	Dust_____	Solvent_____	Noise_____

Family Medical History:

Please indicate below if anyone in your family (Parents, siblings, grandparents, etc.) has ever been diagnosed with the following: Diabetes, Cancer (what type), Heart Disease, Stroke, High Blood Pressure, Mental Illness (what type), Migraines, Asthma/Allergies, Arthritis, Other.

Relative	**Age of onset**	**Disease**	**If Deceased, Cause of Death**
Father			
Mother			
Siblings			
Grandparents			

Current Medications: ☐None Please include non-prescription and herbal medications if you take them regularly.

Drug Name	Strength	Frequency (times per day)

Please indicate any personal history below **Patient Name:_____**

Constitutional Symptoms

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

Eyes

Eye disease or injury	No	Yes
Wear glasses/contact lenses	No	Yes
Blurred or double vision	No	Yes

Ears/Nose/Mouth/Throat

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problem or rhinitis	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

Cardiovascular

Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath when walking or lying flat	No	Yes
Swelling of feet, ankles or hands	No	Yes

Respiratory

Chronic of frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes

Gastrointestinal

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or constipation	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain	No	Yes

Genitourinary

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in force of strain when urinating	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Male – testicle pain	No	Yes
Female – pain with periods	No	Yes
Female – irregular periods	No	Yes
Female – vaginal discharge	No	Yes
Female – # of pregnancies	_____	
Female – # of miscarriages	_____	
Female – date of last Pap smear	_____	

Musculoskeletal

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

Integumentary (skin, breast)

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

Neurological

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Head injury	No	Yes

Psychiatric

Memory loss of confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

Endocrine

Glandular or hormone problem	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat or glove size	No	Yes

Hematologic/Lymphatic

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

Allergic/Immunologic

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	No	Yes
Morphine, Demerol, or other narcotics	No	Yes
Novocain or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin or other serums	No	Yes
Iodine, Merthiolate or other antiseptic	No	Yes

Other drugs/medications:

_____

_____

Known food allergies:

_____

_____

Environmental allergies:

_____

_____

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 health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature Date

Doctor's Review

How did you hear about our office? _____