

# 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 ..... 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
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)

<table border="0" style="width: 100%;"> <tr> <td style="width: 20%;">Cancer .....</td> <td style="width: 10%;">no</td> <td style="width: 10%;">yes</td> <td style="width: 10%;">Relationship _____</td> </tr> <tr> <td>Tuberculosis .....</td> <td>no</td> <td>yes</td> <td>_____</td> </tr> <tr> <td>Diabetes .....</td> <td>no</td> <td>yes</td> <td>_____</td> </tr> <tr> <td>Heart Disease .....</td> <td>no</td> <td>yes</td> <td>_____</td> </tr> <tr> <td>High blood pressure .....</td> <td>no</td> <td>yes</td> <td>_____</td> </tr> </table>	Cancer .....	no	yes	Relationship _____	Tuberculosis .....	no	yes	_____	Diabetes .....	no	yes	_____	Heart Disease .....	no	yes	_____	High blood pressure .....	no	yes	_____	<table border="0" style="width: 100%;"> <tr> <td style="width: 20%;">Stroke .....</td> <td style="width: 10%;">no</td> <td style="width: 10%;">yes</td> <td style="width: 10%;">Relationship _____</td> </tr> <tr> <td>Epilepsy .....</td> <td>no</td> <td>yes</td> <td>_____</td> </tr> <tr> <td>Allergies .....</td> <td>no</td> <td>yes</td> <td>_____</td> </tr> <tr> <td>Anemia .....</td> <td>no</td> <td>yes</td> <td>_____</td> </tr> <tr> <td>Bleeding tendency .....</td> <td>no</td> <td>yes</td> <td>_____</td> </tr> </table>	Stroke .....	no	yes	Relationship _____	Epilepsy .....	no	yes	_____	Allergies .....	no	yes	_____	Anemia .....	no	yes	_____	Bleeding tendency .....	no	yes	_____
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**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	<b>Men only:</b>		
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	<b>Women only:</b>		
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	no	yes
Ear pain	no	yes	Black tarry stools	no	yes	between periods?		
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 \_\_\_\_\_