

# Health History

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Date of last physical examination \_\_\_\_\_

What is the reason for your visit? \_\_\_\_\_

## Symptoms... Check off symptoms you currently have or have had in the past year.

- |   |  |  |  |  |
|---|--|--|--|--|
| <b>GENERAL</b><br><input type="checkbox"/> Chills<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Dizziness<br><input type="checkbox"/> Fainting<br><input type="checkbox"/> Fever<br><input type="checkbox"/> Forgetfulness<br><input type="checkbox"/> Headache<br><input type="checkbox"/> Loss of sleep<br><input type="checkbox"/> Loss of weight<br><input type="checkbox"/> Nervousness<br><input type="checkbox"/> Numbness<br><input type="checkbox"/> Sweats<br><br><b>MUSCLE/JOINT/BONE</b><br>Pain, weakness, numbness in:<br><input type="checkbox"/> Arms<br><input type="checkbox"/> Back<br><input type="checkbox"/> Feet<br><input type="checkbox"/> Hands<br><input type="checkbox"/> Hips<br><input type="checkbox"/> Legs<br><input type="checkbox"/> Neck<br><input type="checkbox"/> Shoulders | <b>GASTROINTESTINAL</b><br><input type="checkbox"/> Appetite poor<br><input type="checkbox"/> Bloating<br><input type="checkbox"/> Bowel changes<br><input type="checkbox"/> Constipation<br><input type="checkbox"/> Diarrhea<br><input type="checkbox"/> Excessive hunger<br><input type="checkbox"/> Excessive thirst<br><input type="checkbox"/> Gas<br><input type="checkbox"/> Hemorrhoids<br><input type="checkbox"/> Indigestion<br><input type="checkbox"/> Nausea<br><input type="checkbox"/> Rectal bleeding<br><input type="checkbox"/> Stomach pain<br><input type="checkbox"/> Vomiting<br><input type="checkbox"/> Vomiting blood<br><br><b>CARDIOVASCULAR</b><br><input type="checkbox"/> Chest pain<br><input type="checkbox"/> High blood pressure<br><input type="checkbox"/> Irregular heart beat<br><input type="checkbox"/> Low blood pressure<br><input type="checkbox"/> Poor circulation<br><input type="checkbox"/> Rapid heart beat<br><input type="checkbox"/> Swelling of ankles<br><input type="checkbox"/> Varicose veins | <b>EYE, EAR, NOSE, THROAT</b><br><input type="checkbox"/> Bleeding gums<br><input type="checkbox"/> Blurred vision<br><input type="checkbox"/> Crossed eyes<br><input type="checkbox"/> Difficulty swallowing<br><input type="checkbox"/> Double vision<br><input type="checkbox"/> Earache<br><input type="checkbox"/> Ear discharge<br><input type="checkbox"/> Hay fever<br><input type="checkbox"/> Hoarseness<br><input type="checkbox"/> Loss of hearing<br><input type="checkbox"/> Nosebleeds<br><input type="checkbox"/> Persistent cough<br><input type="checkbox"/> Ringing in ears<br><input type="checkbox"/> Sinus problems<br><input type="checkbox"/> Vision – Flashes<br><input type="checkbox"/> Vision – Halos<br><br><b>SKIN</b><br><input type="checkbox"/> Bruise easily<br><input type="checkbox"/> Hives<br><input type="checkbox"/> Itching<br><input type="checkbox"/> Change in moles<br><input type="checkbox"/> Rash<br><input type="checkbox"/> Scars<br><input type="checkbox"/> Sore that won't heal | <b>GENITO-URINARY</b><br><input type="checkbox"/> Blood in urine<br><input type="checkbox"/> Frequent urination<br><input type="checkbox"/> Lack of bladder control<br><input type="checkbox"/> Painful urination<br><br><b>MEN ONLY</b><br><input type="checkbox"/> Breast lump<br><input type="checkbox"/> Erection difficulties<br><input type="checkbox"/> Lump in testicles<br><input type="checkbox"/> Penis discharge<br><input type="checkbox"/> Sore on penis<br><input type="checkbox"/> Other | <b>WOMEN ONLY</b><br><input type="checkbox"/> Abnormal Pap Smear<br><input type="checkbox"/> Bleeding between periods<br><input type="checkbox"/> Breast lump<br><input type="checkbox"/> Extreme menstrual pain<br><input type="checkbox"/> Hot flashes<br><input type="checkbox"/> Nipple discharge<br><input type="checkbox"/> Painful intercourse<br><input type="checkbox"/> Vaginal discharge<br><br>Date of last menstrual period _____<br>Date of last pap smear _____<br>Have you had a mammogram? _____<br>Are you pregnant? _____<br>Number of children _____ |
|---|--|--|--|--|

## Conditions... Check off conditions you currently have or have had in the past year.

- |  |  |  |  |   |
|--|--|--|--|---|
| <input type="checkbox"/> Aids<br><input type="checkbox"/> Alcoholism<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Anorexia<br><input type="checkbox"/> Appendicitis<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Bleeding disorders<br><input type="checkbox"/> Breast lump<br><input type="checkbox"/> Bronchitis<br><input type="checkbox"/> Bulimia | <input type="checkbox"/> Cancer<br><input type="checkbox"/> Cataracts<br><input type="checkbox"/> Chemical dependency<br><input type="checkbox"/> Chicken pox<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Emphysema<br><input type="checkbox"/> Epilepsy<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Goiter<br><input type="checkbox"/> Gonorrhea<br><input type="checkbox"/> Gout | <input type="checkbox"/> Heart disease<br><input type="checkbox"/> Hepatitis<br><input type="checkbox"/> Hernia<br><input type="checkbox"/> Herpes<br><input type="checkbox"/> High Cholesterol<br><input type="checkbox"/> HIV Positive<br><input type="checkbox"/> Kidney Disease<br><input type="checkbox"/> Liver Disease<br><input type="checkbox"/> Measles<br><input type="checkbox"/> Migraine Headaches<br><input type="checkbox"/> Miscarriage | <input type="checkbox"/> Mononucleosis<br><input type="checkbox"/> Multiple Sclerosis<br><input type="checkbox"/> Mumps<br><input type="checkbox"/> Pacemaker<br><input type="checkbox"/> Pneumonia<br><input type="checkbox"/> Polio<br><input type="checkbox"/> Prostate Problem<br><input type="checkbox"/> Psychiatric Care<br><input type="checkbox"/> Rheumatic Fever<br><input type="checkbox"/> Scarlet Fever<br><input type="checkbox"/> Stroke | <input type="checkbox"/> Suicide Attempt<br><input type="checkbox"/> Thyroid Problems<br><input type="checkbox"/> Tonsillitis<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Typhoid Fever<br><input type="checkbox"/> Ulcers<br><input type="checkbox"/> Vaginal Infections<br><input type="checkbox"/> Venereal Disease |
|--|--|--|--|---|

## Health Habits...

Check which you use and how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Alcohol	

## Pregnancies...

Tell us about your pregnancies, if applicable.

Year of birth	Sex of birth	Complications, if any

