

HEALTH HISTORY

Name _____ Birth date _____ Age _____ Date _____

Date of last physical exam: _____ What is reason for visit? _____

SYMPTOMS Check () symptoms you currently have or have had in the past year

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

<p><input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts</p>	<p><input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes</p>	<p><input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio</p>	<p><input type="checkbox"/> Prostate problem <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infection <input type="checkbox"/> Venereal Disease</p>
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MEDICATIONS List medications you are currently taking:	ALLERGIES To medications or substances:

FAMILY HISTORY Fill in health information about your family						
Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) If, your blood relatives had any of the following:	
					Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brother(s)					Cancer	
					Chemical Dependency	
					Diabetes	
Sister(s)					Heart Disease, Strokes	
					High Blood Pressure	
					Kidney Disease	

HOSPITALIZATIONS				FEMALE HEALTH HISTORY			
Year	Hospital	Reason and Outcome					
				Age of first menses			
				Date of last period			
				Date of last pap smear			
Serious Illness / Injuries			Date	Outcome	Date of last breast exam		
					Date of last mammogram		
					Type of Birth control used		
					Other		
Have you ever had a blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give approximate dates: _____				HEALTH HABITS Check (✓) which substances you use and describe how much you use.			
LIFESTYLE / ENVIRONMENT What is your major stressor? How do you cope with your stress? Do you have any difficulties sleeping? How many hours of sleep do you get each night? How do you relax? Any Hobbies? Do you exercise regularly? Do you have an exercise program? Please describe Do you live in a new home or recently remodeled? Does your home have new carpet? Paint? Furniture? Do you have sensitivities to certain smells or environments? Do you use perfume or cologne?				Caffeine			
				Tobacco			
				Drugs			
				Other			
				OCCUPATIONAL CONCERNS Check (✓) if your work exposes you to the following:			
				Stress			
				Hazardous Substances			
				Heavy Lifting			
				Other			
				Your occupation:			
				DIET			
				YES NO			
Do you perceive your diet as healthful?							
Do you follow a particular diet?							
Are you a Vegetarian?							
Do you drink soda?							
What kind?				How much?			
How much water do you drink?							
Is it filtered water or from the tap?							
Do you take nutritional supplements							
Please List:							

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for errors or omissions that I may have made in the completion of this form.

Signature _____

Date _____