

# 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)

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	_____	Spouse	_____
Thyroid Disease	no yes	_____	Children	_____
Ulcer	no yes	_____	_____	_____
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 \_\_\_\_\_