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HEALTH HISTORY

Please print in the information below to the best of your ability

Name: _____ Age: _____ Date of Birth: _____

Height: _____ Weight: _____ Which hand do you write with: Right_____ Left _____

Primary Physician: _____ Referring Physician: _____

Other Physicians: _____

Pharmacy (Name and Location): _____

Briefly, state the problem you have been referred for:

Past Medical History: (Check any of the following that you are presently or in the past have been under treatment for):

- ☐ Diabetes
- ☐ Heart Attack
- ☐ Angina
- ☐ Heart Failure
- ☐ Irregular Heartbeat
- ☐ High Blood Pressure
- ☐ Stroke (Include Mini-Strokes)
- ☐ Thyroid Disease
- ☐ Liver Disease
- ☐ Hepatitis/Jaundice
- ☐ Kidney Disease/Failure
- ☐ Bladder Problems
- ☐ Asthma
- ☐ Emphysema
- ☐ High Cholesterol
- ☐ Cancer (list type or area effected)
- ☐ **All other illnesses:**

_____
_____
_____
_____

Other: (For females, include number of pregnancies and deliveries)

SURGERY: (List type of surgery and date/year)

MEDICATIONS: (PLEASE INCLUDE DOSE AND HOW OFTEN YOU TAKE THE MEDICATION)	**ALLERGIES:**

FAMILY: (Give age and present health and list medical problems. If deceased give age and cause of death.)

Mother: _____ Father: _____

Sisters: _____ Brothers: _____

Others: (Major or hereditary conditions in grandparents, aunts, uncles or cousins) _____

SOCIAL: Marital Status: _____ # in Household: _____ Occupation: _____

Tobacco: ☐ Current ☐ Quit ☐ Never. Number of cigarettes/packs a day: _____ Years smoked: _____

Years Quit: _____ Alcohol use: _____ Drugs: _____ Level of education: _____

Review Of Systems: Please circle any personal history below:

☐ Constitutional Symptoms

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

☐ Eyes

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

☐ Ears/se/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 w/walking or lying flat	No	Yes
Swelling of feet, ankles or hands	No	Yes

☐ Respiratory

Chronic or 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 stream 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 _____

☐ Musculoskeletal

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscle 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 lumps	No	Yes
Breast discharge	No	Yes

☐ Neurological

Frequent or recurring headaches	No	Yes
Lightheaded 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 or 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 drier	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	No	Yes

Other drugs/medications:_____

_____

Known Food/Environmental allergies

_____

Doctor's Review (Please do not write in this area)

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 change in my medical status. I also authorize the healthcare staff to perform the services I may need. I have reviewed, agree and consent to the sections relating to policies, consent and authorization in the document provided to me: New Patient Information (Ver 1.3).

Patient's Name **Signature** **Date**