HEALTH HISTORY

PATIENT NAME _____ BIRTHDATE ____/____/____ PATIENT # _____

To help us meet all of 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.

Do you have a living will? _____
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 (food, drugs, environment)
_____
_____

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)

			Relationship				Relationship
Cancer.....	No	Yes	_____	Stroke.....	No	Yes	_____
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 (continued)
(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	Bloody sputum	No	Yes	Joint pain or stiffness	No	Yes
Tire easily or weakness	No	Yes	Wheezing	No	Yes	Swollen joints	No	Yes
Recent weight changes	No	Yes	Chest pain or discomfort	No	Yes	Muscle cramps or spasms	No	Yes
Change in appetite	No	Yes	Purple fingers or lips	No	Yes	Sleeplessness	No	Yes
Sensitivity to cold or heat	No	Yes	Swelling of hands, feet or ankles	No	Yes	Seizures	No	Yes
Persistent fever	No	Yes	Difficulty in breathing	No	Yes	Depression	No	Yes
Night sweats or hot flashes	No	Yes	Palpitations or flutter of the heart	No	Yes	Memory loss	No	Yes
Skin changes	No	Yes	Leg cramps on walking or at night	No	Yes	Poor coordination	No	Yes
Skin trouble or changes	No	Yes	Enlarged veins	No	Yes	Dizziness or fainting spells	No	Yes
Change in nails or hair	No	Yes	Difficulty swallowing	No	Yes	**Men only:**		
Headaches	No	Yes	Heartburn	No	Yes	Discharge from penis?	No	Yes
Easy bleeding or bruising	No	Yes	Frequent belching	No	Yes	Pain or lump in testicles?	No	Yes
Double vision	No	Yes	Abdominal cramping	No	Yes	Impotence?	No	Yes
Blurred vision	No	Yes	Nausea	No	Yes	**Women only:**		
Eye pain	No	Yes	Vomiting	No	Yes	Age period began?		
Infected eyes	No	Yes	Vomited or coughed up blood	No	Yes	How many days between periods?		
Do you wear glasses or contacts?	No	Yes	Chronic diarrhea	No	Yes	Is the flow heavy?	No	Yes
When was your last eye exam			Chronic constipation	No	Yes	Do you bleed or spot between periods?	No	Yes
Ringing in the ears	No	Yes	Rectal bleeding	No	Yes			
Discharge from ears	No	Yes	Black tarry stools	No	Yes	Do you have pain or cramps?	No	Yes
Ear pain	No	Yes	Dark urine	No	Yes	Date of last period?		
Decrease in hearing	No	Yes	Yellow jaundice	No	Yes	Date of last pelvic exam?		
Frequent nosebleeds	No	Yes	Frequent urination (day)	No	Yes	Date of last mammogram?		
Frequent colds	No	Yes	Frequent urination (night)	No	Yes	Any itching in vaginal area?	No	Yes
Sinus trouble	No	Yes	Increase in thirst	No	Yes	Pain with intercourse?	No	Yes
Loss of smell	No	Yes	Painful urination	No	Yes	Type of birth control used?		
Persistent hoarseness	No	Yes	Leakage of urine	No	Yes	Number of pregnancies		
Sore throat	No	Yes	Difficulty in starting urine	No	Yes	Number of full term births		
Sore tongue or gums	No	Yes	Blood in urine	No	Yes	Number of preterm births		
Lump or discharge from breast.	No	Yes	Lack of sex drive	No	Yes			
Chronic or frequent cough	No	Yes	Hemorrhoid	No	Yes			
Shortness of breath	No	Yes	Backaches	No	Yes			

X_____ _____

Signature of patient or parent if minor — Date