PATIENT HEALTH HISTORY

Please help us establish you with our practice by providing your complete health history.

Personal Information:

Name: _____ Date of Birth: _____ Date: _____

Main Issues/Reasons for this Appointment (if possible rank in terms of importance to you):

1. _____
2. _____
3. _____
4. _____
5. _____

Allergies (Medication or Substance)	Type of Reaction

Current Medications	Dose	Directions

Current Vitamins/Herbs/Supplements	Dose	Directions

I. SYMPTOMS Check ( ) symptoms you are currently experiencing.

GENERAL
- ❑ Chills
- ❑ Depression
- ❑ Dizziness
- ❑ Fainting
- ❑ Fever
- ❑ Forgetfulness
- ❑ Headache
- ❑ Loss of sleep
- ❑ Loss of weight
- ❑ Nervousness
- ❑ Numbness
- ❑ Sweats
- ❑ Fatigue

IMMUNE SYSTEM
- ❑ Too many infections
- ❑ Allergies to food
- ❑ Allergies to environment
- ❑ Other concerns _____

_____

MUSCLE/ JOINT /BONE
Pain, weakness. numbness in:
- ❑ Arms ❑ Hips
- ❑ Back ❑ Legs
- ❑ Feet ❑ Neck
- ❑ Hands ❑ Shoulders

GENITO-URINARY
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Daytime ❑ Nighttime
- ❑ Lack of bladder control
- ❑ Painful Urination

GASTROINTESTINAL
- ❑ Appetite poor
- ❑ Bloating
- ❑ Bowel changes
- ❑ Constipation
- ❑ Diarrhea
- ❑ Excessive hunger
- ❑ Excessive thirst
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Indigestion/Heartburn
- ❑ Nausea
- ❑ Rectal bleeding
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Vomiting blood
- ❑ Difficulty swallowing

CARDIOVASCULAR
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Low blood pressure
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Swelling of ankles
- ❑ Varicose veins

PULMONARY
- ❑ Shortness of Breath
- ❑ Wheezing / Asthma
- ❑ Frequent colds
- ❑ Cough-Dry/Irritating/ Persistant

EYE-EAR-NOSE-THROAT
- ❑ Bleeding gums
- ❑ Blurred vision
- ❑ Sore throat
- ❑ Difficulty swallowing
- ❑ Double vision
- ❑ Earache
- ❑ Ear discharge
- ❑ Mouth sores
- ❑ Hoarseness
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Bad breath
- ❑ Ringing in ears
- ❑ Sinus problems
- ❑ Vision - lashes
- ❑ Vision - halos

SKIN
- ❑ Bruise easily
- ❑ Hives
- ❑ Itching
- ❑ Change in moles
- ❑ Rash
- ❑ Scars
- ❑ Sores that won't heal
- ❑ Dry skin / Eczema
- ❑ Hair Loss

NERVOUS SYSTEM
- ❑ Seizures
- ❑ Nerve pain
- ❑ Poor balance
- ❑ Poor coordination
- ❑ Tremors / shaking

MEN only
- ❑ Breast lump
- ❑ Erection difficulties
- ❑ Lump in testicles
- ❑ Penis discharge
- ❑ Sore on penis
- ❑ Other _____

WOMEN only
- ❑ Abnormal Pap smear
- ❑ Bleeding between periods
- ❑ Breast lump
- ❑ Extreme menstrual pain
- ❑ Hot flashes
- ❑ Nipple discharge
- ❑ Breast pain
- ❑ Vaginal discharge
- ❑ Other _____

Age period started: _____

Date of last menstrual period. _____

Date of last Pap Smear. _____

Are you pregnant? _____

Pregnancies _____

Miscarriages _____

Abortions _____

Live Births _____

Age of menopause ____

Hormone replacement. ____

If yes, how many years? ____

II. CONDITIONS Check ( ) conditions you currently have *or have had in the past.*

- ❑ AIDS
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anorexia
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer type _____
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herpes
- ❑ High Cholesterol
- ❑ HIV Positive
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraine Headaches
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problem
- ❑ Psychiatric Care
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease

III. ILLNESSES, INJURIES & OPERATIONS

Illness, injury or operation	Date	Hospital	Treatment	Physician

IV. Family History Fill in health information about your family.

Relation	Age	Healthy	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, Lung problems	
Brothers					❑ Cancer (Type?)	
					❑ Chemical Dependency	
					❑ Diabetes	
					❑ Heart Disease, Strokes	
Sisters					❑ High Blood Pressure	
					❑ Kidney Disease	
					❑ Psychiatric problems	
					❑ Other	

V. HEALTH MAINTENANCE when did you last have a:

Tetanus Shot		Cholesterol Level		Eye Exam		Mammogram		Flu Vaccine	
Pneumovax		Colon Exam		Chest X·ray		Prostate Exam			
Hepatitis Vaccine		Bone Density		EKG		Hemoccult Test			

Do you have a Living Will? _____ If yes, where is this kept? _____

VI. SOCIAL HISTORY Check those that apply.

MARITAL STATUS:
- ❑ Single
- ❑ Married
- ❑ Divorced
- ❑ Widowed

EDUCATION LEVEL COMPLETED:
- ❑ High School
- ❑ College
- ❑ Professional School
- ❑ Other: _____

DO YOU FIND YOUR LIFE:
- ❑ Satisfactory
- ❑ Too Demanding
- ❑ Boring
- ❑ Generally Unsatisfactory

LIVING ARRANGEMENT

❑ Alone ❑ Family ❑ Significant Other ❑ Roomate

❑ Children (list sex and ages) _____

MAJOR RECENT STRESSES: ❑ Money ❑ Job ❑ Marriage ❑ Home Life ❑ Children

❑ Other _____

LIFESTYLE / SELF-CARE ISSUES:	YES	NO	
Do you smoke cigarettes/cigars?	❑	❑	If yes, how many? # years packs per day?
Did you ever smoke?	❑	❑	If yes, when did you quit?
Do you drink alcohol?	❑	❑	If yes, how much? Type & drinks per week?
Do you use recreational drugs?	❑	❑	If yes, which ones?
Do you manage stress well?	❑	❑	Not Sure ❑ Need Help ❑
Do you exercise regularly?	❑	❑	If no, why?
Do you enjoy your job?	❑	❑	If no, why?
Do you allow yourself time to unwind and relax?	❑	❑	If no, why?
Do you sleep soundly and enough?	❑	❑	If no, why?
Are you satisfied with your sex life?	❑	❑	If no, why?
Are you satisfied with your social life?	❑	❑	If no, why?
Are you satisfied with your spiritual life?	❑	❑	If no, why?
Is your diet healthy enough?	❑	❑	Not Sure ❑ Need Help ❑

Parent/Guardian Signature Date

Reviewer Signature Date