

HEALTH HISTORY

The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you.

Date: _____

Patient Name _____ Birthdate _____ Patient # _____

Age _____ Height _____ Weight _____

Chief Complaint _____

History of present illness:

Location: _____
(Where is the pain/problem?)

Quality _____
(Example: normal versus abnormal color, activity, etc.)

Severity _____
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

Duration _____
(How long have you had this pain/problem?, or, When did it start?)

Timing _____
(Does the pain/problem occur at a specific time?)

Context _____
(Where were you at the onset of this pain/problem?)

Associated signs/symptoms _____
(What other associated problems have you been having?)

Modifying factors _____
(What makes the pain/problem worse or better?, or, Have you had previous episodes?)

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	Anemia	no	yes	Back trouble	no	yes	Hepatitis	no	yes
Mumps	no	yes	Bladder Infections	no	yes	High Blood Pressure	no	yes	Ulcer	no	yes
Chickenpox	no	yes	Epilepsy	no	yes	Low Blood Pressure	no	yes	Kidney Disease	no	yes
Whooping Cough	no	yes	Migraine Headaches	no	yes	Hemorrhoids	no	yes	Thyroid Disease	no	yes
Scarlet Fever	no	yes	Tuberculosis	no	yes	Date of last chest x-ray			Bleeding Tendency	no	yes
Diphtheria	no	yes	Diabetes	no	yes	Asthma	no	yes	Any other disease	no	yes
Smallpox	no	yes	Cancer	no	yes	Hives or Eczema	no	yes	(please list):		
Pneumonia	no	yes	Polio	no	yes	AIDS or HIV+	no	yes	_____		
Rheumatic Fever	no	yes	Glaucoma	no	yes	Infectious Mono	no	yes	_____		
Heart Disease	no	yes	Hernia	no	yes	Bronchitis	no	yes	_____		
Arthritis	no	yes	Blood or Plasma Transfusions	no	yes	Mitral Valve Prolapse	no	yes	_____		
Venereal Disease	no	yes				Stroke	no	yes	_____		

Previous Hospitalizations/Surgeries/Serious Illnesses

When?

Hospital, City, State

Medications: (Include nonprescription & herbal supplements)

Patient social history:

Marital status	Single: _____	Married: _____	Separated: _____	Divorced: _____	Widowed: _____
Use of alcohol:	Never: _____	Rarely: _____	Moderate: _____	Daily: _____	
Use of tobacco:	Never: _____	Previously, but	quit: _____	Current packs/day: _____	
Use of drugs:	Never: _____	Type/Frequency: _____			
Excessive exposure at home or work to:	Fumes: _____	Dust: _____	Solvents: _____	Air-borne Particles: _____	Noise: _____

Family medical history:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Review of Systems: Please indicate any personal history below:

<input type="checkbox"/> Constitutional Symptoms		<input type="checkbox"/> Genitourinary		<input type="checkbox"/> Psychiatric	
Good general health lately	No Yes	Frequent urination	No Yes	Memory loss or confusion	No Yes
Recent weight change	No Yes	Burning or painful urination	No Yes	Nervousness	No Yes
Fever	No Yes	Blood in urine	No Yes	Depression	No Yes
Fatigue	No Yes	Change in Force of strain when urinating	No Yes	Insomnia	No Yes
Headaches	No Yes	Incontinence or dribbling	No Yes	<input type="checkbox"/> Endocrine	
<input type="checkbox"/> Eyes		Kidney stones	No Yes	Glandular or Hormone problem	No Yes
Eye disease or injury	No Yes	Sexual difficulty	No Yes	Excessive thirst or urination	No Yes
Wear glasses/contact lenses	No Yes	Male – testicle pain	No Yes	Heat or cold intolerance	No Yes
Blurred or double vision	No Yes	Female – pain with periods	No Yes	Skin becoming dryer	No Yes
<input type="checkbox"/> Ears/Nose/Mouth/Throat		Female – irregular periods	No Yes	Change in hat or glove size	No Yes
Hearing loss or ringing	No Yes	Female – vaginal discharge	No Yes	<input type="checkbox"/> Hematologic/Lymphatic	
Earaches or drainage	No Yes	Female - # of pregnancies	_____	Slow to heal after cuts	No Yes
Chronic sinus problem or rhinitis	No Yes	Female - # of miscarriages	_____	Bleeding or bruising tendency	No Yes
Nose bleeds	No Yes	Female – date of last pap smear	_____	Anemia	No Yes
Mouth sores	No Yes	<input type="checkbox"/> Musculoskeletal		Phlebitis	No Yes
Bleeding gums	No Yes	Joint pain	No Yes	Past transfusion	No Yes
Bad breath or bad taste	No Yes	Joint stiffness or swelling	No Yes	Enlarged glands	No Yes
Sore throat or voice change	No Yes	Weakness of muscles or joints	No Yes	<input type="checkbox"/> Allergic/Immunologic	
Swollen glands in neck	No Yes	Muscle pain or cramps	No Yes	History of skin reaction or other adverse reaction to:	
<input type="checkbox"/> Cardiovascular		Back pain	No Yes	Penicillin or other antibiotics	No Yes
Heart trouble	No Yes	Cold extremities	No Yes	Morphine, Demerol, or other narcotics	No Yes
Chest pain or angina pectoris	No Yes	Difficulty in walking	No Yes	Novocain or other anesthetics	No Yes
Palpitation	No Yes	<input type="checkbox"/> Integumentary (skin, breast)		Aspirin or other pain remedies	No Yes
Shortness of breath w/walking or lying flat	No Yes	Rash or itching	No Yes	Tetanus antitoxin or other serums	No Yes
Swelling of feet, ankles or hands	No Yes	Change in skin color	No Yes	Iodine, Merthiolate or other antiseptic	No Yes
		Change in hair or nails	No Yes	Other drugs/medications:	

- | | | | | | |
|---|----|-----|------------------|----|-----|
| <input type="checkbox"/> Respiratory | | | Varicose veins | No | Yes |
| Chronic or frequent coughs | No | Yes | Breast pain | No | Yes |
| Spitting up blood | No | Yes | Breast lump | No | Yes |
| Shortness of breath | No | Yes | Breast discharge | No | Yes |
| Wheezing | No | Yes | | | |

Known food allergies: _____

Environmental allergies: _____

- | | | | | | |
|--|----|-----|--|----|-----|
| <input type="checkbox"/> Gastrointestinal | | | <input type="checkbox"/> Neurological | | |
| Loss of appetite | No | Yes | Frequent or recurring headaches | No | Yes |
| Change in bowel movements | No | Yes | Light headed or dizzy | No | Yes |
| Nausea or vomiting | No | Yes | Convulsions or seizures | No | Yes |
| Frequent diarrhea | No | Yes | Numbness or tingling sensations | No | Yes |
| Painful bowel movements or constipation | No | Yes | Tremors | No | Yes |
| Rectal bleeding or blood in stool | No | Yes | Paralysis | No | Yes |
| Abdominal pain | No | Yes | Head injury | 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 health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient, Parent or Guardian

Date

Doctor's Review

Signature of Doctor

Date