

HEALTH HISTORY FORM

Name _____ Date of Birth _____ Date _____

Welcome to our practice!! We are happy you chose us to assist you with your health care needs. Please help us by completing **both sides** of this form. This is a confidential record that will be kept in your chart in this office.

Past Medical History: Have you ever had the following? (Circle yes or no. Leave blank if you are unsure.)

Chicken pox	no	yes	Allergies/Hayfever.....	no	yes	Back Problems.....	no	yes
Measles	no	yes	Hives or Eczema.....	no	yes	Arthritis.....	no	yes
Mumps.....	no	yes	Migraines.....	no	yes	Any other disease (please list)_____		
Infectious Mono.....	no	yes	Seizures.....	no	yes	_____		
Tuberculosis.....	no	yes	Stroke.....	no	yes	_____		
Pneumonia.....	no	yes	Anemia.....	no	yes	When was your last:		
Asthma.....	no	yes	Bleeding tendency.....	no	yes	Pap smear _____		
Emphysema.....	no	yes	Blood transfusion.....	no	yes	Mammogram _____		
Rheumatic Fever.....	no	yes	AIDS/HIV.....	no	yes	Breast exam _____		
Mitral valve prolapse.....	no	yes	Venereal disease.....	no	yes	Prostate exam _____		
Heart Disease.....	no	yes	Bladder infections.....	no	yes	PSA test _____		
Heart Attack.....	no	yes	Kidney disease.....	no	yes	Stool test for blood _____		
High blood pressure.....	no	yes	Ulcer.....	no	yes	Colonoscopy _____		
High cholesterol.....	no	yes	Hepatitis.....	no	yes	Chest Xray _____		
Thyroid disease.....	no	yes	Liver disease.....	no	yes	Tuberculosis skin test (PPD)_____		
Diabetes.....	no	yes	Gallbladder problem.....	no	yes	Tetanus shot _____		
Cancer.....	no	yes	Hemorrhoids.....	no	yes	Pneumonia shot _____		
Emotional problem.....	no	yes	Hernia.....	no	yes	Flu shot _____		
Glaucoma.....	no	yes	Osteoporosis.....	no	yes	Hepatitis A & B shots _____		

Serious Illnesses, Surgeries & Hospitalizations:
(please list with date of occurrence)

Current Medications: (include non-prescription medications and vitamins or supplements):

Allergies: (foods, drugs) Please indicate type of reaction.

Family History: Has any blood relative had any of the following? (Circle yes or no. Leave blank if unsure.)

	Relationship		Relationship			
Breast Cancer.....	no	yes	Allergies.....	no	yes	_____
Ovarian Cancer.....	no	yes	Asthma.....	no	yes	_____
Prostate Cancer.....	no	yes	Chronic lung disease.....	no	yes	_____
Colon Cancer.....	no	yes	Stomach/bowel			
Other Cancer.....	no	yes	disease.....	no	yes	_____
Diabetes.....	no	yes	Bleeding tendency.....	no	yes	_____
Heart attack.....	no	yes	Anemia.....	no	yes	_____
Heart disease.....	no	yes	Stroke.....	no	yes	_____
Hypertension.....	no	yes	Mental illness.....	no	yes	_____
High cholesterol.....	no	yes	Drug/alcohol abuse.....	no	yes	_____
Kidney disease.....	no	yes	Glaucoma.....	no	yes	_____
Thyroid disease.....	no	yes	Osteoporosis.....	no	yes	_____
Migraines.....	no	yes	Arthritis.....	no	yes	_____
Seizures.....	no	yes	Other familial disease (please list) _____			

Name _____ Date of Birth _____ Date _____

Social History:

Marital Status: _____ Highest level of education: _____ Occupation: _____
 Frequency/amount of alcohol use: _____ Frequency/amount of tobacco use: _____
 Frequency/amount of drug use: _____ Frequency/amount of caffeine: _____
 Frequency/amount of exercise: _____ Usual weight: _____

Review of Systems: Please indicate whether you have recently had problems with any of the following:

Constitutional

Weight loss or gain no yes
 Fever no yes
 Fatigue no yes

Eyes

Eye disease/injury no yes
 Wear glasses/contacts no yes
 Blurred or double vision no yes

Ears/Nose/Mouth/Throat

Hearing loss or ringing no yes
 Earaches or drainage no yes
 Chronic sinus problems no yes
 Nose bleeds no yes
 Mouth sores no yes
 Bleeding gums no yes
 Bad breath or bad taste no yes
 Sore throat no yes
 Voice change no yes

Cardiovascular

Chest pain/angina no yes
 Heart trouble no yes
 Palpitations no yes
 Short of breath while
 Walking/lying flat no yes
 Swelling of feet/ankles no yes

Respiratory

Chronic/frequent cough no yes
 Spitting up blood no yes
 Shortness of breath no yes
 Wheezing no yes

Gastrointestinal

Nausea or vomiting no yes
 Loss of appetite no yes
 Change in bowel habits no yes
 Constipation no yes
 Frequent diarrhea no yes

Painful bowel movements no yes
 Rectal bleeding no yes
 Blood in stool no yes
 Abdominal pain no yes

Genitourinary

Frequent urination no yes
 Painful urination no yes
 Blood in urine no yes
 Change in force of stream
 while urinating no yes
 Incontinence no yes
 Kidney stones no yes
 Sexual difficulty no yes
 Male: Testicular pain no yes
 Female:
 Irregular periods no yes
 Painful periods no yes
 Vaginal discharge no yes
 Number of pregnancies _____
 Number of miscarriages _____
 Number of deliveries _____

Musculoskeletal

Joint pain no yes
 Joint stiffness no yes
 Weak muscles no yes
 Muscle pain/cramps no yes
 Back pain no yes
 Cold hands/feet no yes
 Difficulty walking no yes

Integumentary

Rash or itching no yes
 Change in skin color no yes
 Change in hair/nails no yes
 Varicose veins no yes
 Breast pain no yes
 Breast lump no yes
 Breast discharge no yes

Neurological

Frequent headaches no yes
 Lightheaded/dizzy no yes
 Seizures/convulsions no yes
 Numbness or tingling no yes
 Tremors no yes
 Paralysis no yes
 Head injury no yes

Psychiatric

Memory loss/confusion no yes
 Nervousness/anxiety no yes
 Depression no yes
 Insomnia no yes

Endocrine

Glandular/hormonal problem no yes
 Excessive thirst or urination no yes
 Heat or cold intolerance no yes
 Skin extremely dry no yes
 Decrease in height no yes

Hematologic/Lymphatic

Slow to heal after cuts no yes
 Bleeding tendency no yes
 Bruise easily no yes
 Anemia no yes
 Phlebitis no yes
 Past blood transfusion no yes
 Enlarged glands no yes

Allergic/Immunologic

Hayfever no yes
 Frequent infections no yes

Reviewed By: _____ Date: _____