HEALTH HISTORY

PATIENT #:_____

Welcome to our practice. Please fill out the information found below to the best of your ability.

Primary Care Physician / Referred By_____

Patient Name _____ Birthdate _____ Date: _____

Chief Complaint:_____

History of present Illness:

Height:_____ Weight:_____

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	If yes how long ____ A B C circle one		
Chickenpox	no	yes	Epilepsy	no	yes	Low Blood Pressure	no	yes	Ulcer	no	yes
Whooping Cough	no	yes	Migraine Headaches	no	yes	Hemorrhoids	no	yes	Kidney Disease	no	yes
Scarlet Fever	no	yes	Tuberculosis	no	yes	Date of last chest x-ray	_____		Thyroid Disease	no	yes
Diphtheria	no	yes	Diabetes	no	yes	Asthma	no	yes	Bleeding Tendency	no	yes
Smallpox	no	yes	Cancer	no	yes	Hives or Eczema	no	yes	Any other disease	no	yes
Pneumonia	no	yes	Polio	no	yes	AIDS or HIV+	no	yes	(please list):		
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			Mitral Valve Prolapse	no	yes			
Venereal Disease	no	yes	Transfusions	no	yes	Stroke	no	yes			

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medications: (Include nonprescription/herbals/vitamins)_____

_____

_____

Pharmacy

name: _____ **Location:** _____ **Phone:** _____

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			

Please see other side

Review of Systems: Please indicate any personal history below:

☐ **Constitutional Symptoms**
- Good general health lately ..... No Yes
- Recent weight change ..... No Yes
- Fever ..... No Yes
- Fatigue ..... No Yes
- Headaches ..... No Yes

☐ **Eyes**
- Eye disease or injury ..... No Yes
- Wear glasses/contact lenses ..... 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 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 strain 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 smear. _____

☐ **Musculoskeletal**
- Joint pain ..... No Yes
- Joint stiffness or swelling ..... No Yes
- Weakness of muscles 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 lump ..... No Yes
- Breast discharge ..... No Yes

☐ **Neurological**
- Frequent or recurring headaches No Yes
- Light headed 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 dryer ..... 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, Merthiolate or other antiseptic ..... No Yes
- Other drugs/medications: _____

_____

Known food allergies: _____

_____

Environmental allergies: _____

_____

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 or Responsible Party Date

Doctor's Review

_____ _____

Signature of Doctor Date

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