DALLAS DIAGNOSTIC ASSOCIATION

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.

Who referred you? _____

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

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

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

_____

_____

_____

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

_____

_____

Family History: Please indicate in the spaces below any family members with a history of: tuberculosis, diabetes, heart disease, cancer, emphysema, kidney disease, asthma, bleeding tendencies, anemia, epilepsy, glaucoma, high blood pressure, gout, arthritis, ulcer, stroke, nervous breakdown, gall bladder disease.

	Age	Health Problems	Age at Death	Cause
Father	_____	_____	_____	_____
Paternal Grandfather	_____	_____	_____	_____
Paternal Grandmother	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____
Maternal Grandmother	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
(how many in all? ____)		_____	_____	_____
Sisters	_____	_____	_____	_____
(how many in all? ____)		_____	_____	_____
Sons	_____	_____	_____	_____
(how many in all? ____)		_____	_____	_____
Daughters	_____	_____	_____	_____
(how many in all? ____)		_____	_____	_____

Any other family members with illnesses noted above? _____

_____

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: _____

(over)

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

Other Doctors you see: **Specialty**

Any additional information:

Review of Systems: *(Check all symptoms you have had recently)*

Constitutional
__ Fever or chills
__ Loss of appetite
__ Weight change over 10 lbs

Eyes
__ Wear glasses or contacts
__ Vision problem
__ Eye discomfort or irritation

Ears, Nose, Mouth, Throat
__ Stuffy or runny nose
__ Nosebleeds
__ Hearing loss
__ Earache or ringing in ears
__ Sore throat
__ Sores or lumps in mouth
__ Hoarseness of voice

Cardiovascular
__ Chest discomfort
__ Irregular or rapid heartbeat
__ Swelling of ankles or legs
__ Leg pain with walking

Respiratory
__ Cough
__ Coughing up blood
__ Shortness of breath
__ Wheezing

Integumentary
__ Moles or skin problems
__ Breast lumps
__ Discharge from breast
__ Abnormal lumps or growths

Gastrointestinal
__ Nausea or vomiting
__ Constipation
__ Diarrhea
__ Abdominal discomfort
__ Bloating or excess gas
__ Change in bowel habits
__ Change in stool size
__ Black bowel movements
__ Rectal bleeding
__ Hemorrhoids
__ Difficulty swallowing
__ Heartburn
__ Intolerance of fatty foods
__ Yellow skin or brown urine

Genitourinary
__ Discomfort with urination
__ Excess urination
__ Difficulty urinating
__ Red or bloody urine
__ Lose urine accidentally
__ Vaginal discharge
__ Abnormal vaginal bleeding
__ Discharge from penis
__ Testicle pain or swelling
__ Sexual problems

Endocrine
__ Excessive thirst or urination
__ Intolerance of hot or cold
__ Excessive perspiration

Date of your last menstrual period: _____

Musculoskeletal
__ Muscle aches
__ Muscle weakness
__ Backache
__ Joint discomfort or stiffness

Neurologic
__ Headache
__ Dizziness
__ Numbness or tingling
__ Tremor or shaking
__ Fainting or blackouts
__ Difficulty walking
__ Sleep disturbance
__ Seizures
__ Confusion or memory loss

Psychiatric
__ Sadness or depression
__ Anxiety or nervousness
__ Suicidal or violent thoughts
__ Hallucinations

Hematologic Lymphatic
__ Lymps in neck or under arms
__ Abnormal bleeding or bruising

Allergic/Immunologic
__ Sneezing
__ "Hay fever"
__ Hives

List below all other matters that you would like to be addressed:

Please Sign: _____ **Date:** _____

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