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 disease……	no	yes	_____
Other Cancer……...	no	yes	_____	Bleeding tendency…….	no	yes	_____
Diabetes……..no		yes	_____	Anemia…….……	no	yes	_____
Heart attack……	no	yes	_____	Stroke……..……....	no	yes	_____
Heart disease……...	no	yes	_____	Mental illness……	no	yes	_____
Hypertension……...	no	yes	_____	Drug/alcohol abuse……....	no	yes	_____
High cholesterol.……	no	yes	_____	Glaucoma……..……	no	yes	_____
Kidney disease……...	no	yes	_____	Osteoporosis…..……..	no	yes	_____
Thyroid disease……..	no	yes	_____	Arthritis……	no	yes	_____
Migraines……...	no	yes	_____	Other familial disease (please list) _____			
Seizures……	no	yes	_____				

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**: _____

Updated 3/7/02