HEALTH HISTORY

Patient Name:_____ DOB:_____ Date:_____

PRESENTING SYMPTOMS	
Please describe your symptoms:	
When did this start:	How frequently does this occur:
What relieves these symptoms:	
Have you been to the emergency room in the past six months? If so, where?	

PATIENT'S MEDICAL HISTORY (Please indicate illnesses or conditions you have had)

☐ BLOOD CLOT ☐ BLOOD TRANSFUSION	☐ THYROID PROBLEMS ☐ KIDNEY STONES	☐ HEART ATTACK ☐ HEPATITIS ☐ HIGH BLOOD PRESSURE
☐ EMPHYSEMA ☐ ASTHMA/BRONCHITIS	☐ STROKE ☐ SEIZURE	☐ HEART DISEASE ☐ MITRAL VALVE PROLAPSE
☐ DIABETES ☐ DEPRESSION ☐ CANCER LOCATION:	☐ STOMACH ULCER ☐ PEPTIC ULCER DISEASE ☐ GASTROESOPHAGEAL REFLUX DISEASE	☐ CONGESTIVE HEART FAILURE ☐ HIGH CHOLESTEROL ☐ CHRONIC OBSTRUCTIVE PULMONARY DISEASE

CURRENT MEDICATIONS (Taken on a regular basis: Prescription or over-the-counter drugs)

Name of Medication	Strength /Dose	Name of Medication	Strength/ Dose

ALLERGIES OR REACTIONS TO MEDICATIONS

Name of Drug	Reaction

IMMUNIZATION (Indicate year of last shot or if reaction occurred)

Tetanus: Flu: Pneumovax: Other:

Are you on a special diet? ☐ No ☐ Yes – What diet?

PREVIOUS SURGERIES

Type	Year	Hospital

Reaction to anesthesia with any surgery? ☐ NO ☐ YES – Describe?

FAMILY HISTORY

HEALTH HISTORY

Patient Name:_____DOB:_____Date:_____

Relative	Living	Deceased	Age	Health Problems/Cause of Death
Father				
Mother				
Spouse				
Brothers				
Sisters				
Children				

Please indicate illnesses which have occurred in any of your blood relatives:

☐ Diabetes	☐ Tuberculosis	Other:
☐Heart Disease	☐ Cancer	
☐ Stroke	☐ Kidney Disease	
☐High Blood Pressure	☐ Nervous Disorder	
☐ Abnormal Bleeding	☐ Allergy	

SOCIAL HISTORY

☐ Married ☐ Widowed ☐ Divorced ☐Separated ☐ Single — How many people live with you?

Occupation: — Spouse's Occupation:

Children (age, sex):

Tobacco use: ☐ Never ☐ Current ☐ Former Type: ☐ Cigarettes ☐ Cigars ☐ Chew ☐ Pipe
_____ packs per day for _____ (years) total ☐ E-Cigarette Device Type:_____ Frequency:_____
Alcohol use: ☐ Never ☐ Rarely ☐ Socially ☐ Daily ☐ Weekly Type: _____
Caffeine use: ☐ Yes ☐ No Type: _____ Amount Daily: _____

REVIEW OF SYSTEMS (Indicate problems or changes you have experienced in the last six weeks)

Constitutional
☐ chills/fever
☐ fatigue
☐ night sweats
☐ weight gain
☐ weight loss

Eyes, Ears, Nose, Throat
☐ ear drainage
☐ eye discharge/pain
☐ hearing loss
☐ nasal drainage
☐ sinus pressure
☐ troubles swallowing
☐ visual changes
☐ nose bleeds
☐ dentures
☐glaucoma
☐ cataracts

Respiratory
☐ chronic cough
☐ shortness of breath
☐ wheezing
☐ apnea
☐ pneumonia
☐ emphysema

Cardiovascular
☐ chest pain
☐ edema
☐ palpitations
☐ leg pain while walking
☐ feet ulcers

Gastrointestinal
☐ abdominal pain
☐ blood in stool
☐ change in stools
☐ constipation
☐ diarrhea
☐ heartburn
☐ loss of appetite
☐ nausea
☐ vomiting

Genitourinary
☐ painful urination
☐ blood in urine
☐ urinary frequency
☐ urinary incontinence
☐ kidney stones

Metabolic/Endocrine
☐ gout
☐ hypoglycemic

Neurological
☐ dizziness
☐ extremity weakness
☐ extremity numbness
☐ headache
☐ memory loss
☐ tremors
☐ confusion/disorientation
☐ facial neuropathy
☐ frequent falls
☐ blackouts

Psychiatric
☐ anxiety
☐ sleep disturbance

Skin
☐contact allergy
☐ hives
☐ itching
☐ mole changes
☐ rash
☐ skin lesions

Musculoskeletal
☐ back pain
☐ joint pain
☐ joint swelling
☐ muscle weakness
☐ neck pain
☐ arthritis

Hematologic/Lymphatic
☐ easy bleeding
☐ easy bruising
☐ lymphadenopathy
☐ hematoma
☐ anemia
☐ leg edema

Immunological
☐ environmental allergies
☐ food allergies
☐ seasonal allergies