

HEALTH HISTORY

Patient Name: _____ DOB: _____ Date: _____

PRESENTING SYMPTOMS

Please describe your symptoms:

When did this start:	How frequently does this occur:
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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)

<input type="checkbox"/> BLOOD CLOT	<input type="checkbox"/> THYROID PROBLEMS	<input type="checkbox"/> HEART ATTACK <input type="checkbox"/> HEPATITIS
<input type="checkbox"/> BLOOD TRANSFUSION	<input type="checkbox"/> KIDNEY STONES	<input type="checkbox"/> HIGH BLOOD PRESSURE
<input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> STROKE	<input type="checkbox"/> HEART DISEASE
<input type="checkbox"/> ASTHMA/BRONCHITIS	<input type="checkbox"/> SEIZURE	<input type="checkbox"/> MITRAL VALVE PROLAPSE
<input type="checkbox"/> DIABETES <input type="checkbox"/> DEPRESSION	<input type="checkbox"/> STOMACH ULCER	<input type="checkbox"/> CONGESTIVE HEART FAILURE
<input type="checkbox"/> CANCER	<input type="checkbox"/> PEPTIC ULCER DISEASE	<input type="checkbox"/> HIGH CHOLESTEROL
LOCATION:	<input type="checkbox"/> GASTROESOPHAGEAL REFLUX DISEASE	<input type="checkbox"/> 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

HEALTH MANAGEMENT: (please enter most recent date)

Tetanus: Flu: Pneumovax: Colonoscopy: Mammogram:
Are you on a special diet? No Yes – What diet?

PREVIOUS SURGERIES

Type	Year	Hospital

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

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FAMILY HISTORY				
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:				
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Tuberculosis		Other: _____
<input type="checkbox"/> Heart Disease		<input type="checkbox"/> Cancer		
<input type="checkbox"/> Stroke		<input type="checkbox"/> Kidney Disease		
<input type="checkbox"/> High Blood Pressure		<input type="checkbox"/> Nervous Disorder		
<input type="checkbox"/> Abnormal Bleeding		<input type="checkbox"/> Allergy		
SOCIAL HISTORY				
<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single			How many people live with you? _____	
Occupation: _____			Spouse's Occupation: _____	
Children (age, sex): _____				
Tobacco use: <input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Former Type: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Chew <input type="checkbox"/> Pipe _____ packs per day for _____ (years) total <input type="checkbox"/> E-Cigarette Device Type: _____ Frequency: _____				
Alcohol use: <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Socially <input type="checkbox"/> Daily <input type="checkbox"/> Weekly Type: _____				
Caffeine use: <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____ Amount Daily: _____				
REVIEW OF SYSTEMS (Indicate problems or changes you have experienced in the last six weeks)				
Constitutional <input type="checkbox"/> chills/fever <input type="checkbox"/> fatigue <input type="checkbox"/> night sweats <input type="checkbox"/> weight gain <input type="checkbox"/> weight loss Eyes, Ears, Nose, Throat <input type="checkbox"/> ear drainage <input type="checkbox"/> eye discharge/pain <input type="checkbox"/> hearing loss <input type="checkbox"/> nasal drainage <input type="checkbox"/> sinus pressure <input type="checkbox"/> troubles swallowing <input type="checkbox"/> visual changes <input type="checkbox"/> nose bleeds <input type="checkbox"/> dentures <input type="checkbox"/> glaucoma <input type="checkbox"/> cataracts Respiratory <input type="checkbox"/> chronic cough <input type="checkbox"/> shortness of breath <input type="checkbox"/> wheezing <input type="checkbox"/> apnea <input type="checkbox"/> pneumonia <input type="checkbox"/> emphysema	Cardiovascular <input type="checkbox"/> chest pain <input type="checkbox"/> edema <input type="checkbox"/> palpitations <input type="checkbox"/> leg pain while walking <input type="checkbox"/> feet ulcers Gastrointestinal <input type="checkbox"/> abdominal pain <input type="checkbox"/> blood in stool <input type="checkbox"/> change in stools <input type="checkbox"/> constipation <input type="checkbox"/> diarrhea <input type="checkbox"/> heartburn <input type="checkbox"/> loss of appetite <input type="checkbox"/> nausea <input type="checkbox"/> vomiting Genitourinary <input type="checkbox"/> painful urination <input type="checkbox"/> blood in urine <input type="checkbox"/> urinary frequency <input type="checkbox"/> urinary incontinence <input type="checkbox"/> kidney stones	Metabolic/Endocrine <input type="checkbox"/> gout <input type="checkbox"/> hypoglycemic Neurological <input type="checkbox"/> dizziness <input type="checkbox"/> extremity weakness <input type="checkbox"/> extremity numbness <input type="checkbox"/> headache <input type="checkbox"/> memory loss <input type="checkbox"/> tremors <input type="checkbox"/> confusion/disorientation <input type="checkbox"/> facial neuropathy <input type="checkbox"/> frequent falls <input type="checkbox"/> blackouts Psychiatric <input type="checkbox"/> anxiety <input type="checkbox"/> sleep disturbance	Skin <input type="checkbox"/> contact allergy <input type="checkbox"/> hives <input type="checkbox"/> itching <input type="checkbox"/> mole changes <input type="checkbox"/> rash <input type="checkbox"/> skin lesions Musculoskeletal <input type="checkbox"/> back pain <input type="checkbox"/> joint pain <input type="checkbox"/> joint swelling <input type="checkbox"/> muscle weakness <input type="checkbox"/> neck pain <input type="checkbox"/> arthritis Hematologic/Lymphatic <input type="checkbox"/> easy bleeding <input type="checkbox"/> easy bruising <input type="checkbox"/> lymphadenopathy <input type="checkbox"/> hematoma <input type="checkbox"/> anemia <input type="checkbox"/> leg edema Immunological <input type="checkbox"/> environmental allergies <input type="checkbox"/> food allergies <input type="checkbox"/> seasonal allergies	

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