

# HEALTH HISTORY

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Date of last physical: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

## SYMPTOMS Check symptoms you have or have had in the past.

### GENERAL

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Headache
- Nervousness
- Sweats
- Trembles
- Gained/Lost more than 10 lbs
- Armpits or groin swelling
- Sleeping difficulties
- Tobacco use
- Alcoholic drinks
- Sleeping pills

### MUSCLE/BONE/JOINT

- Pain, weakness, numbness in:
- Arms       Hands
  - Back       Hips
  - Feet       Legs
  - Shoulders       Neck

### GASTROINTESTINAL

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger/thirst
- Gas
- Hemorrhoids
- Heartburn
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

### EYES

- Glasses
- Eyesight worsening
- Blurry vision
- Double vision
- Vision – halos/flashes
- Eye pain/itching
- Watery eyes

### EARS

- Earaches
- Ear discharge
- Loss of hearing
- Ringing in ears
- Motion sickness

### NOSE & THROAT

- Congested nose
- Runny nose
- Sinus problems
- Nosebleeds
- Sore throat
- Difficulty swallowing
- Hoarseness
- Enlarged tonsils
- Sneezing spells

### MOUTH

- Bleeding gums
- Gum/Jaw swellings
- Sore tongue
- Taste changes

### CARDIOVASCULAR

- Chest pain
- High blood pressure
- Irregular heartbeat
- Rapid heartbeat
- Poor circulation
- Varicose veins
- Swelling of ankles
- Leg cramps
- Heart murmur

### URINARY

- Blood in urine
- Burning urination
- Night/Day frequency
- Lack of bladder control

### RESPIRATORY

- Shortness of breath
- Wheezes or gasps
- Chest colds
- Persistent cough
- Coughs up phlegm
- Coughs up blood

### SKIN

- Bleeds easily
- Bruise easily
- Hives
- Itching/Burning
- Changes in moles
- Rash
- Scars
- Sore won't heal

### MALES ONLY

- Weak urine stream
- Prostate problem
- Burning or discharge
- Testicular lumps
- Painful testicles
- Breast lump
- Erection difficulties
- Sore on penis
- Other

### FEMALES ONLY

- Abnormal pap
- Bleeding b/w periods
- Breast lump or pain
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Vaginal itching/discharge
- Vaginal bleeding
- Vaginal infections
- Post-menopausal or hysterectomy
- Other

Last menstrual period \_\_\_\_/\_\_\_\_/\_\_\_\_

Last pap test \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you had a mammogram?

YES       NO

## CONDITIONS

Check conditions you have or have had in the past.

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> AIDS               | <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> HIV Positive       | <input type="checkbox"/> Scarlet Fever    |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Suicide Attempt  |
| <input type="checkbox"/> Anorexia           | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Measles            | <input type="checkbox"/> Thyroid Problem  |
| <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Tonsillitis      |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Typhoid fever    |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gout                | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Bulimia            | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Pneumonia          |   |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Polio              |   |
| <input type="checkbox"/> Cataracts          | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Psychiatric Care   |   |
|   | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Rheumatic Fever    |   |