HEALTH HISTORY

Please know that this form will serve as your Comprehensive Health History. We will ask you to update this form every 6 months to a year in order to keep our records current. Our providers will refer to this document at each visit.

Patient Name: _____ **Date of Birth:** _____

Current Phone # (home) _____ (cell) _____

Email Address: _____

Known Drug Allergies _____

Patient Social History:

Marital Status: Single: _____ Married: _____ Separated _____ Divorced _____ Widowed _____

Use of Alcohol: Never _____ Rarely _____ Moderate _____ Daily _____

Use of Tobacco: Never _____ Previously but, Quit _____ Current Packs/day: _____

Use of Drugs: Never _____ Type/Frequency *Would you like information on how to quit NO YES

Current Prescribed Medications: (please provide dosage and frequency)

Ex: Hyzaar 10mg once at bedtime Ex: Orthotricyclen once daily in am

(Note: If need further room please include on separate sheet of paper)

Gynecological History

How old were you when you first started your menstrual cycle _____ How many times have you been pregnant _____

Number of Deliveries(if Any) _____ Number of Miscarriages(if Any) _____ Number of Abortions(if Any) _____

Pain with Periods No Yes Irregular Cycles No Yes Vaginal Discharge No Yes

Previous Hospitilizations/Surgeries/Serious Illnesses	**When**	**Hopsital/City/State**

Past Medical History

Please circle "no" or "yes" if you have ever had one of the following. (Leave blank if uncertain)

Measles	no	yes	Anemia	no	yes	Back Trouble	no	yes	Thyroid Disease	no	yes
Mumps	no	yes	Bladder Infections	no	yes	Hemorrhoids	no	yes	Bleeding Tendency	no	yes
Chickenpox	no	yes	Epilepsy	no	yes	Asthma	no	yes	Arthritis	no	yes
Whooping Cough	no	yes	Migraine Headaches	no	yes	Hives or Eczema	no	yes	High Blood Pressure	no	yes
Scarlet Fever	no	yes	Tuberculosis	no	yes	Psoriasis	no	yes	Low Blood Pressure	no	yes
Diphtheria	no	yes	Polio	no	yes	AIDS or HIV+	no	yes	Ulcer	no	yes
Smallpox	no	yes	Glaucoma	no	yes	Infectious Mono	no	yes	Kidney Disease	no	yes
Pneumonia	no	yes	Hernia	no	yes	Bronchitis	no	yes	Venereal Disease	no	yes
Rheumatic Fever	no	yes	Blood or Plasma			Mitral Valve Prolapse	no	yes	Any other Disease please list		
Heart Disease	no	yes	Transfusions	no	yes	Stroke	no	yes			
						Hepatitis	no	yes			

Patient / Family History

Cancer If yes / Who? _____ (Ex: Breast - Maternal Grandmother)

Diabetes If yes / Who? _____

(OVER)

Other Relevant Family medical History

	Age	Diseases	If Deceased, cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

Review of Systems: Please indicate any personal history below:

◯ Constitutional Symptoms

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

◯ Ears/Nose/Mouth/Throat

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic Sinus problem or rhinitis	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

◯ Cardiovascular

Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpatation	No	Yes
Shortness of breath w/walking or lying flat	No	Yes
Swelling of feet, ankles or hands	No	Yes

◯ Respiratory

Do you have a persistent cough or throat clearing not associated w/a known illness (lasting more than 3 weeks)?	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes

◯ Endocrine

Glandular or hormone problem	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat or glove size	No	Yes

◯ Genitourinary

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in force of strain when urinating	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes

◯ Musculoskeletal

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

◯ Integumentary (skin, breast)

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

◯ Neurological

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Head injury	No	Yes

◯ Psychiatric

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

◯ Eyes

Eye Disease or injury	No	Yes
Wear glasses/contact lenses	No	Yes
Blurred or double vision	No	Yes

◯ Gastrointestinal

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or constipation	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal Pain	No	Yes

◯ Hematologic/Lymphatic

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes
	No	Yes

◯ Allergic/Immunologic

History of skin reaction or other adverse reaction to:	No	Yes
Penicillin or other antibiotics	No	Yes
Morphine, Demerol / other	No	Yes
Novocain or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin / other	No	Yes
Iodine, Merthiolate / other	No	Yes

Other drugs/medications: _____

Known Food Allergies: _____

Environmental Allergies: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to preform the necessary services I may need.

Signature of Patient, Parent or Guardian	Date	Signature of Healthcare provider	Date Reviewed
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