HEALTH HISTORY

First Name

Middle Name / MI

Last Name

Date of Birth

To help us meet all your healthcare needs, please fill out this form completely. This is a confidential record of your medical history and will be kept in this office.

Today's Date

Place of birth

Highest level in school

Marital Status

Occupation

When was your last physical exam?

Name of previous doctor

Phone of previous doctor

Hobbies

Exercise/recreation Habits:

Patient Smoking Status

Patient Smoking Frequency

Patient Smoking End Date

Alcohol (type & amount per week)

Caffeine (type & amount per week)

Street drugs (type & amount per week)

Usual weight

Date of last dental exam

Please list all drug allergies:

Please list all medical problems you have experienced and indicate year these occurred:

Please list all medicines you are currently taking (include nonprescription drugs):

List all surgeries, hospitalizations, and fractures (include date occurred):

Chief Complaint

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

_____

Past Medical History

Have you ever had the following:

(leave blank if uncertain)

Check all that apply

- ☐ Chickenpox
- ☐ Whooping Cough
- ☐ Scarlet Fever
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Heart Disease
- ☐ Arthritis
- ☐ Venereal Disease
- ☐ Bladder Infections

If other disease, please list

_____

Check all that apply

- ☐ Migraine headaches
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Blood or Plasma transfusions
- ☐ Hepatitis B
- ☐ Hemorrhoids
- ☐ Asthma
- ☐ Epilepsy
- ☐ Anemia

If Venereal Disease

_____

Check all that apply

- ☐ Hives or Eczema
- ☐ AIDS or HIV+
- ☐ Mitral Valve Prolapse
- ☐ Stroke
- ☐ Hepatitis C
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Bleeding tendency
- ☐ Any other disease

Family History

Has any blood relative had any of the following:

(leave blank if uncertain)

Tuberculosis

◯ Yes ◯ No

Relationship

_____

Diabetes

◯ Yes ◯ No

Relationship

_____

High blood pressure

◯ Yes ◯ No

Relationship

_____

Stroke

◯ Yes ◯ No

Relationship

_____

Asthma

◯ Yes ◯ No

Relationship

_____

Drug or Alcohol Problem

◯ Yes ◯ No

Relationship

_____

Leukemia

◯ Yes ◯ No

Migraine Headaches

◯ Yes ◯ No

Obesity

◯ Yes ◯ No

Relationship

Relationship

Relationship

Thyroid Disease

Yes No

Depression

Yes No

High Cholesterol

Yes No

Relationship

Relationship

Relationship

Kidney Disease

Yes No

Gout

Yes No

Other Health Issue

Yes No

Relationship

Relationship

Relationship

Cancer

Yes

No

Type

Relationship

Heart Disease

Yes

No

Type

Relationship

Epilepsy

Yes

No

Type

Relationship

Bleeding Tendency

Yes

No

Type

Relationship

Anemia

Yes

No

Type

Relationship

Chronic Lung Disease

Yes

No

Type

Relationship

Mental Illness

- ◯ Yes
- ◯ No

Type _____

Relationship _____

Father

Present age, or age of death _____

If living, health
◯ Good ◯ Fair ◯ Poor

If deceased, cause of death _____

Mother

Present age, or age of death _____

If living, health
◯ Good ◯ Fair ◯ Poor

If deceased, cause of death _____

Siblings

Present age, or age of death _____

If living, health
◯ Good ◯ Fair ◯ Poor

If deceased, cause of death _____

Present age, or age of death _____

If living, health
◯ Good ◯ Fair ◯ Poor

If deceased, cause of death _____

Present age, or age of death _____

If living, health
◯ Good ◯ Fair ◯ Poor

If deceased, cause of death _____

Present age, or age of death _____

If living, health
◯ Good ◯ Fair ◯ Poor

If deceased, cause of death _____

Present age, or age of death _____

If living, health
◯ Good ◯ Fair ◯ Poor

If deceased, cause of death _____

Spouse

Present age, or age of death _____

If living, health
◯ Good ◯ Fair ◯ Poor

If deceased, cause of death _____

Children

Present age, or age of death _____

If living, health
◯ Good ◯ Fair ◯ Poor

If deceased, cause of death _____

Present age, or age of death _____

If living, health
◯ Good ◯ Fair ◯ Poor

If deceased, cause of death _____

Present age, or age of death	If living, health	If deceased, cause of death
_____	◯ Good ◯ Fair ◯ Poor	_____
_____	◯ Good ◯ Fair ◯ Poor	_____
_____	◯ Good ◯ Fair ◯ Poor	_____
_____	◯ Good ◯ Fair ◯ Poor	_____

Do you have now or have you had within the past year:

(leave blank if uncertain)

Check all that apply

- ☐ Chronic cough > 1 month
- ☐ Memory loss
- ☐ Weakness or paralysis
- ☐ Persistent fever > 1 month
- ☐ Seizures
- ☐ Recent weight changes > 10 lbs
- ☐ Sleeplessness
- ☐ Night sweats or hot flashes
- ☐ Change in nails or hair
- ☐ Easy bleeding or bruising

Check all that apply

- ☐ Headaches
- ☐ Decrease in hearing
- ☐ Ringing in the ears
- ☐ Sinus trouble
- ☐ Persistent hoarseness
- ☐ Lump or discharge from breast
- ☐ Backaches
- ☐ Joint pain or stiffness
- ☐ Swollen joints
- ☐ Heartburn

Check all that apply

- ☐ Leg cramps on walking or at night
- ☐ Swelling of hands, feet or ankles
- ☐ Difficulty in breathing
- ☐ Palpitations or fluttering of the heart
- ☐ Visible blood in the stool
- ☐ Hemorrhoids
- ☐ Vomited or coughed up blood
- ☐ Chronic diarrhea
- ☐ Chronic constipation
- ☐ Rectal bleeding

Check all that apply

- ☐ Frequent urination (day)
- ☐ Frequent urination (night)
- ☐ Increase in thirst
- ☐ Difficulty in starting urine
- ☐ Leakage of urine
- ☐ Depression
- ☐ Do you wear glasses or contacts
- ☐ Double vision
- ☐ Blurred vision

When was your last eye exam?

_____

Men Only:

Discharge from Penis

◯ Yes ◯ No

Impotence

◯ Yes ◯ No

Pain or Lump in Testicles

◯ Yes ◯ No

Women only:
(leave blank if uncertain)

Age period began?

_____

How many days do periods last?

_____

How many days between periods?

_____

Is the flow heavy?

◯ Yes ◯ No

Do you bleed or spot between periods?

◯ Yes ◯ No

Do you have pain or cramps with your period?

◯ Yes ◯ No

Date of last period?

_____

Date of last PAP Smear?

_____

Date of last mammogram?

_____

Type of birth control used?

_____

Number of pregnancies?

_____

Number of full term births?

_____

Number of preterm births?

_____

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 (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

Signature of patient or parent if minor

Date

_____