

# Health History

**Please complete all applicable questions to the best of your knowledge. If necessary, you may use the space at the end of this form to complete any answers or provide additional information.**

Patient: \_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Date of Birth: MM / DD / YYYY

Home Address: \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Marital Status:  S  M  W  D  Sep Do you have a living will?  Y  N

**MEDICAL CONDITIONS**

**If either you or a family member has or had any of these conditions, check (✓) the box by the condition listed. For family member, indicate their relationship to you (e.g., mother, father, sibling). Please provide a brief description.**

Condition	Self	Description	Family Member	Description
Arthritis				
Asthma				
Back Problems				
Blood in Stool				
Cancer				
Change in Bowels				
Chicken Pox				
Dental Problems				
Depression				
Diabetes				
Emphysema				
Hearing Problems				
Heart Problems				
Hepatitis				
High Blood Pressure				
High Cholesterol				
Kidney Problems				
Leg Swelling				
Liver Problems				
Lung Problems				
Measles				
Migraine Headaches				
Mononucleosis				
Mumps				
Panic Attacks				
Seizures				
Sexually Transmitted Disease				
Skin Problems				
Stroke				
Thyroid Problems				
Other:				
Other:				
Other:				

## PROBLEM CHECKLIST

If you have recently or recurrently noted the any of the following problems, please check (✓) the box next to the condition listed.

<b>General</b>	<input type="checkbox"/> Fever <input type="checkbox"/> Sweats <input type="checkbox"/> Unintended weight change (how much over what period? _____)	<input type="checkbox"/> Chills <input type="checkbox"/> Malaise or "feeling ill" <input type="checkbox"/> Fatigue
<b>Head</b>	<input type="checkbox"/> Headache	<input type="checkbox"/> Head injury
<b>Ears</b>	<input type="checkbox"/> Ringing <input type="checkbox"/> Ear pain <input type="checkbox"/> Ear discharge	<input type="checkbox"/> Change in hearing <input type="checkbox"/> Blockage <input type="checkbox"/> Dizziness
<b>Nose</b>	<input type="checkbox"/> Congestion <input type="checkbox"/> Persistently discolored discharge <input type="checkbox"/> Sinus pressure	<input type="checkbox"/> Clear discharge <input type="checkbox"/> Post nasal drip <input type="checkbox"/> Sinus pain
<b>Throat</b>	<input type="checkbox"/> Sore throat <input type="checkbox"/> Laryngitis <input type="checkbox"/> Itchy throat	<input type="checkbox"/> Dental problem <input type="checkbox"/> Persistent hoarseness <input type="checkbox"/> Snoring
<b>Eyes</b>	<input type="checkbox"/> Change in vision <input type="checkbox"/> Flashing or scintillating lights <input type="checkbox"/> Partial loss of vision (central, peripheral, or field) <input type="checkbox"/> Eye pain	<input type="checkbox"/> Sudden loss of vision <input type="checkbox"/> Dark spots or "floaters" <input type="checkbox"/> Eye discharge <input type="checkbox"/> Itchy or irritable
<b>Heart</b>	<input type="checkbox"/> Chest pain or pressure <input type="checkbox"/> Swelling of feet or ankles	<input type="checkbox"/> Palpitations <input type="checkbox"/> Racing heart
<b>Lungs</b>	<input type="checkbox"/> Trouble breathing (intermittent or constant) <input type="checkbox"/> Cough	<input type="checkbox"/> Wheezing <input type="checkbox"/> Painful breathing
<b>Digestive</b>	<input type="checkbox"/> Heartburn or acid reflux <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Blood in stool <input type="checkbox"/> Excessive bloating or gas	<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Constipation <input type="checkbox"/> Black tarry stool
<b>Bones and Joints</b>	<input type="checkbox"/> Back pain <input type="checkbox"/> Joint pain (stiffness or restricted mobility)	<input type="checkbox"/> Neck pain <input type="checkbox"/> Muscle aches
<b>Neurological</b>	<input type="checkbox"/> Weakness <input type="checkbox"/> Abnormal sensations <input type="checkbox"/> Seizures	<input type="checkbox"/> Numbness <input type="checkbox"/> Fainting <input type="checkbox"/> Restless legs
<b>Psychological</b>	<input type="checkbox"/> Anxious <input type="checkbox"/> Feeling hopeless, helpless, or worthless <input type="checkbox"/> Unable to enjoy life <input type="checkbox"/> Uncontrollable anger or irritability <input type="checkbox"/> Wanting to hide, disappear, or die	<input type="checkbox"/> Panic attack <input type="checkbox"/> Persistent sadness <input type="checkbox"/> Insomnia <input type="checkbox"/> Poor appetite or stress eating <input type="checkbox"/> Wanting to hurt someone
<b>Skin</b>	<input type="checkbox"/> Abnormal or changing mole <input type="checkbox"/> Lesions of concern <input type="checkbox"/> Swollen glands <input type="checkbox"/> Change in texture	<input type="checkbox"/> Rashes <input type="checkbox"/> Dryness <input type="checkbox"/> Bruising <input type="checkbox"/> Hair or nail changes

## IMMUNIZATIONS

Please list month and year of your most recent immunizations.

Hepatitis A	MM / YYYY	Measles	MM / YYYY	Tetanus <sup>1</sup>	MM / YYYY	Chicken Pox	MM / YYYY
Hepatitis B	MM / YYYY	Flu <sup>2</sup>	MM / YYYY	Pneumonia <sup>3</sup>	MM / YYYY	Meningococcal	MM / YYYY
	MM / YYYY		MM / YYYY		MM / YYYY		MM / YYYY

<sup>1</sup> Recommended every 10 years    <sup>2</sup> Recommended every year    <sup>3</sup> Recommended every 5 years

**ALLERGIES**

Are you allergic or intolerant to any medications?  
If "yes," please list and describe your reaction(s).

Y  N

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**MEDICATIONS**

Please list all medications you are using including vitamins, herbal supplements, and contraception.

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**SURGERIES**

Please list any surgeries or procedures (include colonoscopies) you have had with approximate dates.

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**PREVENTIVE HEALTH**

Please provide the following information:

Caffeine? <input type="checkbox"/> Y <input type="checkbox"/> N Type: _____ Caffeinated beverages per day? _____	Alcohol? <input type="checkbox"/> Y <input type="checkbox"/> N Type? _____ Drinks per week? _____ Quit date? <u>MM</u> / <u>YYYY</u>
Tobacco? <input type="checkbox"/> Y <input type="checkbox"/> N Type: _____ Packs per day? _____ Quit date? <u>MM</u> / <u>YYYY</u>	Other substances? <input type="checkbox"/> Y <input type="checkbox"/> N Drug(s)? _____ Frequency? _____
Seat belts? <input type="checkbox"/> Always <input type="checkbox"/> Occ. <input type="checkbox"/> Never	Helmet use? <input type="checkbox"/> Always <input type="checkbox"/> Occ. <input type="checkbox"/> Never
Drive at speed limit? <input type="checkbox"/> Always <input type="checkbox"/> Occ. <input type="checkbox"/> Never	Protective sports gear? <input type="checkbox"/> Always <input type="checkbox"/> Occ. <input type="checkbox"/> Never
Number of days >30 minutes exercise per week? _____	Foreign travel planned? <input type="checkbox"/> Y <input type="checkbox"/> N
Do you have reason to fear for your safety? <input type="checkbox"/> Y <input type="checkbox"/> N	Have you ever been physically or mentally harmed by another? <input type="checkbox"/> Y <input type="checkbox"/> N
Other "high risk" activities (e.g., skydiving, motorcycles, scuba diving)? <input type="checkbox"/> Y <input type="checkbox"/> N Type? _____	

**FOR WOMEN**

Please provide the following information:

Number of pregnancies? _____ How many resulted in live birth(s)? _____ Miscarriage(s)? _____ Abortion(s)? _____	
Date of last period? <u>MM</u> / <u>YYYY</u>	Could you be pregnant now? <input type="checkbox"/> Y <input type="checkbox"/> N
Last Pap Smear or female exam? <u>MM</u> / <u>YYYY</u>	Last mammogram? <u>MM</u> / <u>YYYY</u>
Method of birth control? _____	Age at first period or menopause? _____
Prior abnormal Pap Smear? <input type="checkbox"/> Y <input type="checkbox"/> N If so, year: <u>YYYY</u>	Sexually active? <input type="checkbox"/> Y <input type="checkbox"/> N
History of human papilloma virus? <input type="checkbox"/> Y <input type="checkbox"/> N	Planning pregnancy in next year? <input type="checkbox"/> Y <input type="checkbox"/> N

**FOR MEN**

**Please provide the following information:**

Last PSA (blood prostate level)? <u>MM</u> / <u>YYYY</u>		Sexually active? <input type="checkbox"/> Y <input type="checkbox"/> N
Urine flow problems? <input type="checkbox"/> Y <input type="checkbox"/> N	Prostate problems? <input type="checkbox"/> Y <input type="checkbox"/> N	Lump or pain in testicle? <input type="checkbox"/> Y <input type="checkbox"/> N
Erection issues? <input type="checkbox"/> Y <input type="checkbox"/> N	Loss of height? <input type="checkbox"/> Y <input type="checkbox"/> N	Lack of energy? <input type="checkbox"/> Y <input type="checkbox"/> N

**FOR CHILDREN**

**Please provide the following information:**

Normal development? <input type="checkbox"/> Y <input type="checkbox"/> N	School performance issues? <input type="checkbox"/> Y <input type="checkbox"/> N
Normal growth? <input type="checkbox"/> Y <input type="checkbox"/> N	Social or friends concerns? <input type="checkbox"/> Y <input type="checkbox"/> N
Normal language? <input type="checkbox"/> Y <input type="checkbox"/> N	Behavioral concerns <input type="checkbox"/> Y <input type="checkbox"/> N

**Is there anything of an unusually sensitive nature you would like to discuss with your physician?**  Y  N

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**ADDITIONAL INFORMATION**

**Please use this space to complete any of the above questions or provide other relevant information.**

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\_\_\_\_\_  
Signature of the Patient or the Patient's Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient