HEALTH HISTORY

Patient Name ______________________ Birthdate: ______________ Patient # __________

To help us meet all your healthcare needs, please fill out **both sides** of this form completely in ink. 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 ______________________
Occupation ______________________
Previous occupations ______________________
Marital status ______________________
Hobbies ______________________
Exercise/recreation ______________________
Habits:
Smoking (type & amount per day) __________
If former smoker, date quit __________
Alcohol (type & amount per week) __________
Caffeine (type & amount per day) __________
Street drugs (type & amount per day) __________
Usual weight ______________________
Date of last dental exam ______________________
Please list all allergies (foods, drugs, environment)
____
____

When was your last physical exam? ______________
Name of doctor ______________ Phone __________
Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred:
____
____
____
____

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

Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred):
____
____

Chief Complaints
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: (Circle "no" or "yes", leave blank if uncertain)

Measles	No	Yes	Migraine Headaches	No	Yes	Hives or Eczema	No	Yes
Mumps	No	Yes	Tuberculosis	No	Yes	AIDS or HIV+	No	Yes
Chickenpox	No	Yes	Diabetes	No	Yes	Infectious Mono	No	Yes
Whooping cough	No	Yes	Cancer	No	Yes	Bronchitis	No	Yes
Scarlet Fever	No	Yes	Polio	No	Yes	Mitral Valve Prolapse	No	Yes
Diphtheria	No	Yes	Glaucoma	No	Yes	Stroke	No	Yes
Smallpox	No	Yes	Hernia	No	Yes	Hepatitis	No	Yes
Pneumonia	No	Yes	Blook or Plasma Transfusions	No	Yes	Ulcer	No	Yes
Rheumatic Fever	No	Yes	Back trouble	No	Yes	Kideny Disease	No	Yes
Heart Disease	No	Yes	High or Low Blood Pressure	No	Yes	Thyroid Disease	No	Yes
Arthritis	No	Yes	Hemorrhoids	No	Yes	Bleeding Tendency	No	Yes
Venereal Disease	No	Yes	Date of last chest x-ray ________			Any Other Disease (please list) ________	No	Yes
Anemia	No	Yes	Asthma	No	Yes			
Bladder Infections	No	Yes						
Epilepsy	No	Yes						

Family History
Has any blood relative had the following: (Circle "no" or "yes", leave blank if uncertain)

			Relationship				Relationship
Cancer	No	Yes	________	Stroke	No	Yes	________
Tuberculosis	No	Yes	________	Epilepsy	No	Yes	________
Diabetes	No	Yes	________	Allergies	No	Yes	________
Heart Disease	No	Yes	________	Anemia	No	Yes	________
High Blood Pressure	No	Yes	________	Bleeding Tendency	No	Yes	________

Family History (continued)
(Circle "no" or "yes", leave blank it .certain)

			Relationship		Presen or age ot	If living, health (good, fair, poor) If deceased, cause of death
Asthma	No	Yes		Father		
Chronic Lung Disease	No	Yes		Mother		
Drug or Alcohol Problem	No	Yes		Siblings		
ital Illness	No	Yes				
Leukemia	No	Yes				
Migraine Headaches	No	Yes				
Obesity	No	Yes		Spouse		
Thyroid Disease	No	Yes		Children		
Ulcer	No	Yes				
Depression	No	Yes				
High Cholesterol	No	Yes				
Kidney Disease	No	Yes				
Cglaucoma	No	Yes				
Gout	No	Yes				

Do you have now or have you had within the past year: (Circle "no" or "yes", leave blank if uncertain)

Weakness or paralysis	No	Yes	Bloody sputum	No	Yes	Joint pain or stiffness	No	Yes
Tire easily or weakness	No	Yes	Wheezing	No	Yes	Swollen joints	No	Yes
Recent weight changes	No	Yes	Chest pain or discomfort	No	Yes	Muscle cramps or spasms	No	Yes
Change in appetite	No	Yes	Purple fingers or lips	No	Yes	Sleeplessness	No	Yes
Sensitivity to cold or heat	No	Yes	Swelling of hands, feet or ankles	No	Yes	Seizures	No	Yes
Persistent fever	No	Yes	Difficulty in breathing	No	Yes	Depression	No	Yes
Night sweats or hot flashes	No	Yes	Palpitations/fluttering of the heart	No	Yes	Memory loss	No	Yes
Skin rash	No	Yes	Leg cramps on walking or at night	No	Yes	Poor coordination	No	Yes
Skin rtrouble or changes	No	Yes	Enlarged veins	No	Yes	Dizziness or fainting spells	No	Yes
Change in nails or hair	No	Yes	Difficulty swallowing	No	Yes	A living will or	No	Yes
headaches	No	Yes	Heartburn	No	Yes	advance directive	No	Yes
sy bleeding or bruising	No	Yes	Frequent belching	No	Yes	**Men Only:**	No	Yes
ouble vision	No	Yes	Abdominal cramping	No	Yes	Discharge from penis	No	Yes
Blurred vision	No	Yes	Nausea	No	Yes	Pain or lump in testicles	No	Yes
Eye pain	No	Yes	Vomiting	No	Yes	Impotence	No	Yes
Infected eyes	No	Yes	Vomited or coughed up blood	No	Yes	**Women Only:**	No	Yes
Do you wear glasses/contacts	No	Yes	Chronic diarrhea	No	Yes	Age period began		
Date of last eye exam	No	Yes	Chronic constipation	No	Yes	How many days do peridos last?		
Rining in the ears	No	Yes	Rectal bleeding	No	Yes	How many days between periods?		
Discharge from ears	No	Yes	Black tarry stools	No	Yes	Is the flow heavy?	No	Yes
Ear pain	No	Yes	Dark urine	No	Yes	Do you bleed or spot		
Decrease in hearing	No	Yes	Yellow jaundice	No	Yes	between periods?	No	Yes
Frequent nosebleeds	No	Yes	Frequent urination (day)	No	Yes	Do you have pain or cramps'	No	Yes
Frequent colds	No	Yes	Freqeunt urination (night)	No	Yes	Date of last period?		
Sinus trouble	No	Yes	Increase in thirst	No	Yes	Date of last pelvic exam?		
Loss of smell	No	Yes	Painful urination	No	Yes	Date of last mammogram?		
Persistent hoarseness	No	Yes	Leakage of urine	No	Yes	Any itching in vaginal area?	No	Yes
Sore throat	No	Yes	Difficulty in starting urine	No	Yes	Pain with intercourse?	No	Yes
Sore tongue or gums	No	Yes	Blood in urine	No	Yes	Type of birth control used?		
Lump or discharge from breast	No	Yes	Lack of sex drive	No	Yes	Number of pregnancies		
Chronic or frequent cough	No	Yes	Hemorrhoids	No	Yes	Number of full-term births		
Shortness of breath	No	Yes	Backaches	No	Yes	Number of preterm births		

Signature of patient or parent if minor

Date

M.D. Signature

Revised: