Health History

HEALTH HISTORY OF: NAME ____
REASON(S) FOR VISIT TODAY: ____
HOSPITALIZATIONS: Please list **overnight** hospital stays only.

YEAR	DESCRIBE ILLNES, OPERATION, OR BIRTH	YEAR	DESCRIBE ILLNESS, OPERATION OR BIRTH

FAMILY HEALTH PROBLEMS (Illness you could inherit): Grandparents__________________________
Mother ______________________ **Father**______________________
Brother/s ______________________ **Sister/s** ______________________ **Aunts/Uncles** ______________________

YOUR HEALTH PROBLEMS: Please write (P) for 'past' & (C) for 'current' **Explanation**

Ear Problems: ( ) Hearing problem ( ) Ears ringing/tinnitus ( ) Dizzy spells ( ) Ear wax problem ( ) Ear pain ( ) Other__________
Eye Problems: ( ) Decreased vision ( ) Eye pain ( ) Glaucoma ( ) Cataracts ( ) Blurred vision ( ) Double vision ( ) Other __________
Nose/Sinus Problems: ( ) Allergies ( ) Nose bleeds ( ) Sinus infections ( ) Recurrent sore throats ( ) Hoarseness ( ) Other __________
Lung Problems: ( ) Pneumonia ( ) Pleurisy ( ) Cough ( ) Bronchitis ( ) Asthma or wheezing ( ) Shortness of breath ( ) Other__________
Chest or Heart Problem: ( ) Chest pain ( ) Angina ( ) High blood pressure ( ) Heart condition ( ) Murmur ( ) Irregular pulse ( ) Other__________
Circulation Problems: ( ) Leg pain ( ) Cold feet ( ) Varicose veins ( ) Blood clots or phlebitis ( ) Swollen feet ( ) Other__________
Digestive/Intestine Problem: ( ) Loss of appetite ( ) Difficult to swallow ( ) Heartburn ( ) Ulcers ( ) Reflux ( ) Nausea ( ) Vomiting __________
( ) Abdominal pain ( ) Jaundice ( ) Hepatitis ( ) Gallbladder trouble ( ) Diarrhea ( ) Constipation ( ) Malabsorption __________
( ) Diverticulosis/Diverticulitis ( ) Crohn's disease. ( ) Colitis ( ) Bloody or tar like stools ( ) Hemorrhoids ( ) Hernia ( ) Other __________
Kidney/Urinary Problems: ( ) Overactive bladder ( ) Excessive night time urination ( ) Urgency to urinate __________
( ) Urinary leakage ( ) Decrease urine flow ( ) Stress or cough incontinence ( ) Blood in urine ( ) Pain or burning on urination __________
( ) Urine infections ( ) Excessive urination ( ) Kidney stones ( ) Prostate problems/enlarge prostate/BPH ( ) Other__________
Nerve/Brain Problems: ( ) Headaches/Migraines ( ) Tremor/hands shake ( ) Seizures/Epilepsy ( ) Strokes ( ) Numbness ( ) Memory loss__________
Muscle/Joints/ Bones: ( ) Limb weakness ( ) Arthritis or joint pain ( ) Back pain, recurrent ( ) Gout ( ) Broken bone or joint injury __________
( ) Osteoporosis ( ) Lupus ( ) Fibromyalgia ( ) Muscle cramps ( ) Muscle pain ( ) Scoliosis/Curvature of spine ( ) Other__________
Skin Problems: ( ) Rashes ( ) Hives ( ) Psoriasis ( ) Eczema ( ) Skin cancers ( ) Recurrent skin infections or boils ( ) Hair loss ( ) Other__________
Emotional/Psychiatric: ( ) Nervousness ( ) Depression ( ) Concentration problems ( ) Sleep problems ( ) Mood swings ( ) Other__________
( ) Suicide thoughts ( ) Suicide attempts ( ) Past mental problems or treatment ( ) Past/Present "nerve or antidepressant pills"__________
( ) Panic Attacks ( ) Anxiety ( ) Decreased Sex/Life Enjoyment ( ) Past DWI ( ) Criminal/Felony Arrest/Conviction __________
( ) Marital problems ( ) Marital abuse ( ) Hallucinations ( ) Alcohol abuse ( ) Drug abuse (Street or prescription abuse) __________
Endocrine/Gland Problems: ( ) Diabetes ( ) Thyroid problems ( ) Female/Estrogen hormone problems ( ) Male/Testosterone problem__________
( ) Penile erection problems/Erectile dysfunction ( ) Vaginal dryness ( ) Hot flashes ( ) Pituitary/Growth hormone problems__________
Past or current Infections: ( ) Tuberculosis ( ) Malaria ( ) Measles ( ) Chickenpox ( ) Rheumatic Fever ( ) Polio ( ) Mumps __________
( ) German Measles/Rubella ( ) Herpes ( ) STD's ( ) Gonorrhea ( ) Syphilis ( ) Chlamydia ( ) HIV/AIDS …__________
( ) Hepatitis ( ) Whooping cough/Pertussis ( ) Staph. Infections/Boils ( ) Lyme Disease ( ) Other infectious diseases__________
Other Problems: ( ) Dizzy Spells ( ) Fainting Spells ( ) Anemia ( ) Bruise easily ( ) Blood disorders ( ) Easily fatigued ( ) Nutrition problem__________
( ) Cancer (Type?) When Diagnosed? How was it treated?):__________
Substance usage: ( ) Alcohol, type __________Amount __________ ( ) Coffee/Tea __________ cups/day__________
( ) Smoking or chewing tobacco __________ packs/day ( ) Street/ illicit drugs, types__________
Health Habits: ( ) Exercise, type__________ Frequency __________ Currently Dieting?: ( )Yes ( )No__________
Past Vaccinations/year given: ( )Flu/year_______( )Tetanus(Td)/year_______( )Pneumonia/year_______( )Hepatitis/year_______( )Tuberculosis test/year__________
Past Testing/year done: Last general physical/year________ Rectal or stool testing/year________ Cholesterol/year_______ Eye/year________ Dental exam/year__________
Female/Menstruation History: ( ) Abnormal Vaginal Discharge ( ) Vaginal Irritation ( ) Vaginal Dryness ( ) Frequent Vaginal Infections __________
Menstruation: ( ) Regular ( ) Irregular ( ) Cramps or pain ( ) Length of menstrual flow in days____________ List 1st day of last menstrual period: __________
Female Sexual problems: ( ) Pain during or after intercourse ( ) Bleeding during or after sex ( ) Loss of sexual desire ( ) Difficulty with orgasm or climax __________
Pregnancies: Total Number of Pregnancies_______ Induced (Legal) Abortions ______ Miscarriages ______ Premature (Live) Births _______Full Term (Live) Births ________
Current Birth Control Method: __________ Do you desire birth control counseling or prescription? ( ) Yes ( ) No
Date of last Pap __________ ( ) Normal ( ) Abnormal Date of last mammogram:__________ ( ) Normal ( ) Abnormal
Social History: Employed ( ) Yes ( ) No Job description__________ Work injury/Description__________
Current Married: ( ) Yes ( ) No ( ) Never Number of past divorces________ Education Level______________ Hobbies__________

Medication History (Only medications you are currently taking): Please include vitamins, herbal remedies, and supplements****

Drug Name	Strength	Doses Per Day	Drug Name	Strength	Doses Per Day

List any medication reactions or allergies (Please describe type of reaction):
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____

I certify this is a true, accurate and complete medical history: ______________________ ______________
Signature of patient or guardian **Date**