

# Patient Health History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

## General

- | Past                     | Current                  |                    |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Poor Appetite      |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive Appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | Insomnia           |
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue            |
| <input type="checkbox"/> | <input type="checkbox"/> | Fevers             |
| <input type="checkbox"/> | <input type="checkbox"/> | Night Sweats       |
| <input type="checkbox"/> | <input type="checkbox"/> | Sweat Easily       |
| <input type="checkbox"/> | <input type="checkbox"/> | Chills             |
| <input type="checkbox"/> | <input type="checkbox"/> | Localized Weakness |
| <input type="checkbox"/> | <input type="checkbox"/> | Strong Thirst      |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____       |

## Cardiovascular

- | Past                     | Current                  |                        |
|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure    |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure     |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Clots            |
| <input type="checkbox"/> | <input type="checkbox"/> | Palpitations           |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting               |
| <input type="checkbox"/> | <input type="checkbox"/> | Phlebitis              |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pain             |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular Heart Beat   |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold Hands/Feet        |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling of Hands/Feet |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____           |

## Female

- | Past                     | Current                  |                             |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary Tract Infections    |
| <input type="checkbox"/> | <input type="checkbox"/> | Vaginal Infections          |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain/Itching of Genitalia   |
| <input type="checkbox"/> | <input type="checkbox"/> | Genital Lesion/Discharge    |
| <input type="checkbox"/> | <input type="checkbox"/> | Pelvic Inflammatory Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Pap Smear          |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular Periods           |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful Menstrual Periods   |
| <input type="checkbox"/> | <input type="checkbox"/> | Premenstrual Syndrome       |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Bleeding           |
| <input type="checkbox"/> | <input type="checkbox"/> | Menopausal Syndrome         |
| <input type="checkbox"/> | <input type="checkbox"/> | Breat Lumps                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____                |

## Skin and Hair

- | Past                     | Current                  |                      |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Rashes/Hives/Itching |
| <input type="checkbox"/> | <input type="checkbox"/> | Eczema               |
| <input type="checkbox"/> | <input type="checkbox"/> | Pimples              |
| <input type="checkbox"/> | <input type="checkbox"/> | Dryness              |
| <input type="checkbox"/> | <input type="checkbox"/> | Tumors, Lumps        |

## Respiratory

- | Past                     | Current                  |                                       |
|--------------------------|--------------------------|---------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Bronchitis                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Colds                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Obstructive Pulmonary Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Cough                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughing Blood                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Production of Phlegm                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____                          |

## Neurological

- | Past                     | Current                  |                               |
|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures or Tremors           |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness or Tingling of Limbs |
| <input type="checkbox"/> | <input type="checkbox"/> | Concussion                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Paralysis                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Breat Lumps                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____                  |

## Head and Neck

- | Past                     | Current                  |                |
|--------------------------|--------------------------|----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness      |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting       |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck Stiffness |
| <input type="checkbox"/> | <input type="checkbox"/> | Enlarged lymph |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches      |
| <input type="checkbox"/> | <input type="checkbox"/> | Concussions    |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____   |

## Gastro-Intestinal

- | Past                     | Current                  |                              |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Vomiting                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Belching                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood in Stools/Black Stools |
| <input type="checkbox"/> | <input type="checkbox"/> | Bad Breath                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Rectal Pain                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain or Cramps               |
| <input type="checkbox"/> | <input type="checkbox"/> | Indigestion                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Gall Bladder Disorder        |
| <input type="checkbox"/> | <input type="checkbox"/> | Gas                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____                 |

## Psychological

- | Past                     | Current                  |                        |
|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Depression             |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety/Stress         |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritability           |
| <input type="checkbox"/> | <input type="checkbox"/> | Treated for Emotional/ |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychological Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____           |

## Ears

- | Past                     | Current                  |                   |
|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Infection         |
| <input type="checkbox"/> | <input type="checkbox"/> | Ringing           |
| <input type="checkbox"/> | <input type="checkbox"/> | Decreased Hearing |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____      |

## Infection Screening

- | Past                     | Current                  |                      |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | HIV                  |
| <input type="checkbox"/> | <input type="checkbox"/> | TB                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis            |
| <input type="checkbox"/> | <input type="checkbox"/> | Gonorrhea            |
| <input type="checkbox"/> | <input type="checkbox"/> | Syphillis            |
| <input type="checkbox"/> | <input type="checkbox"/> | Genital Warts or HPV |
| <input type="checkbox"/> | <input type="checkbox"/> | Herpes: Oral/Genital |

## Eyes

- | Past                     | Current                  |                   |
|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Blurred Vision    |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor Night Vision |
| <input type="checkbox"/> | <input type="checkbox"/> | Spots             |
| <input type="checkbox"/> | <input type="checkbox"/> | Cataracts         |
| <input type="checkbox"/> | <input type="checkbox"/> | Concussions       |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____      |

## Genito-Urinary

- | Past                     | Current                  |                      |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones        |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain with Urination  |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination   |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood in Urine       |
| <input type="checkbox"/> | <input type="checkbox"/> | Urgency to Urinate   |
| <input type="checkbox"/> | <input type="checkbox"/> | Unable to Hold Urine |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____         |

## Nose, Throat, and Mouth

- | Past                     | Current                  |                        |
|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Nose Bleeds            |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus Infection        |
| <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever/Allergies    |
| <input type="checkbox"/> | <input type="checkbox"/> | Recurring Sore Throats |
| <input type="checkbox"/> | <input type="checkbox"/> | Grinding Teeth         |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Swallowing  |

## Male

- | Past                     | Current                  |                     |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Impotence           |
| <input type="checkbox"/> | <input type="checkbox"/> | Weak Urinary Stream |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____        |

## Patient History (cont.)

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Family History:** Complete for each family member, placing an X in the appropriate box:

	Self	Mother	Father	Sister/Brother	Spouse	Child
Allergies						
Blood Disorder/Anemia						
Diabetes						
Cancer or Tumors						
Seizures						
High Blood Pressure						
Kidney or Bladder Disorder						
Stomach or Intestinal Disorder						
Drug Abuse						
Tuberculosis						
Heart Disease						
Stroke						
Depression/Mental Illness						
Other						
Age at Death						

**Major Hospitalizations -** If you have ever been hospitalized for any serious medical illness or operation, write in your most recent hospitalizations below

Year	Operation of Illness	Name of Hospital	City and State

**Previous Pregnancies:**

Total Pregnancies:          Living:          Ectopic:          Induced Abortions:          Miscarriages:

**Medicines -** Mark an X in the box next to any of the following that you are now taking

- |   |   |  |                                |
|---|---|--|--------------------------------|
| <input type="checkbox"/> aspirin              | <input type="checkbox"/> ibuprofen      | <input type="checkbox"/> acetaminophen           | <input type="checkbox"/> Other |
| <input type="checkbox"/> antacids             | <input type="checkbox"/> laxatives      | <input type="checkbox"/> cold tablets            |                                |
| <input type="checkbox"/> oral contraceptives  | <input type="checkbox"/> diet pills     | <input type="checkbox"/> tranquilizers           |                                |
| <input type="checkbox"/> fiber supplements    | <input type="checkbox"/> sleeping pills | <input type="checkbox"/> hay fever tablets       |                                |
| <input type="checkbox"/> blood pressure pills | <input type="checkbox"/> blood thinning | <input type="checkbox"/> insulin, diabetic pills |                                |

Vitamins (please list):

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Herbs (please list):

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**Drug Allergies:**

**Habits:** Please check any of the habits listed below which apply to you now or in the past.

Coffee	yes <input type="checkbox"/>	no <input type="checkbox"/>	Cups per day/week	age started	age quit
Tobacco:	yes <input type="checkbox"/>	no <input type="checkbox"/>	Cigarettes per day	age started	age quit
Marijuana	yes <input type="checkbox"/>	no <input type="checkbox"/>	Use per day/week	age started	age quit
Alcohol:	yes <input type="checkbox"/>	no <input type="checkbox"/>	Use per day/week	age started	age quit
Crack/Cocaine:	yes <input type="checkbox"/>	no <input type="checkbox"/>	Use per day/week	age started	age quit
Heroin:	yes <input type="checkbox"/>	no <input type="checkbox"/>	Use per day/week	age started	age quit
Other:				age started	age quit