HEALTH HISTORY

Ht. _____
Wt. _____

Patient Name _____ Today's Date _____
Age _____ Birthdate _____ Date of last physical examination _____
What is your reason for today's visit? _____

SYMPTOMS Check ✓ symptoms you currently have or have had in the past year.

GENERAL	GASTROINTESTINAL	EYE,EAR, NOSE,THROAT	CARDIOVASCULAR	SKIN
☐Chills	☐Appetite poor	☐Bleeding Gums	☐Chest Pain	☐Bruise easily
☐Depression	☐Bloating	☐Blurred Vision	☐High Blood Pressure	☐Hives
☐Dizziness	☐Bowel Changes	☐Crossed Eyes	☐Irregular Heart Beat	☐Itching
☐Fainting	☐Constipation	☐Difficulty Swallowing	☐Low Blood Pressure	☐Change in moles
☐Fever	☐Diarrhea	☐Double Vision	☐Poor Circulation	☐Rash
☐Forgetfulness	☐Excessive Hunger	☐Earache	☐Rapid Heart Beat	☐Scars
☐Headache	☐Excessive Thirst	☐Ear Discharge	☐Swelling of ankles	☐Sores that won't heal
☐Loss of Sleep	☐Gas	☐Hay Fever	☐Varicose veins	
☐Loss of Weight	☐Hemorrhoids	☐Hoarseness		
☐Nervousness	☐Indigestion	☐Loss of Hearing		
☐Numbness	☐Nausea	☐Nosebleeds		
☐Sweats	☐Rectal Bleeding	☐Persistent Cough		
	☐Stomach Pain	☐Ringing in Ears		
	☐Vomiting	☐Sinus Problems		
	☐Vomiting Blood	☐Vision-Flashes		
		☐Vision-Halos		

MUSCLE/JOINT/BONE
Pain, Weakness, Numbness in:

☐Arms ☐Back ☐Feet ☐Hands
☐Hips ☐Legs ☐Neck ☐Shoulders

GENITO-URINARY

☐Blood in urine ☐Lack of bladder control
☐Frequent urination ☐Painful urination

MEN ONLY	WOMEN ONLY		PULMONARY
☐Breast Lump	☐Abnormal Pap Smear	☐Vaginal Discharge	☐Chest Pain
☐Erection Difficulties	☐Bleeding between periods	☐Other	☐Shortness of Breath
☐Lump in testicles	☐Breast Lump	Date of last menstrual period	☐Tightness of Chest
☐Penis Discharge	☐Extreme menstrual pain	Date of last pap smear	☐Wheezing
☐Sore on Penis	☐Hot flashes	Have you had a mammogram? ☐Y ☐N	
☐Other	☐Nipple discharge	Are you pregnant? ☐Y ☐N	
	☐Painful Intercourse	# of Children	

CONDITIONS Check ✓ conditions you have or have had in the past year.

☐AIDS	☐Bulimia	☐Gonorrhea	☐Measles	☐Psychiatric Care	☐Vaginal Infections
☐Alcoholism	☐Cancer	☐Gout	☐Migraine Headaches	☐Rheumatic Fever	☐Venereal Disease
☐Anemia	☐Cataracts	☐Heart Disease	☐Miscarriage	☐Scarlet Fever	
☐Anorexia	☐Chemical Dependency	☐Hepatitis	☐Mononucleosis	☐Stroke	
☐Appendicitis	☐Chicken Pox	☐Hernia	☐Multiple Sclerosis	☐Suicide Attempt	
☐Arthritis	☐Diabetes	☐Herpes	☐Mumps	☐Thyroid Problems	
☐Asthma	☐Emphysema	☐High Cholesterol	☐Pacemaker	☐Tonsillitis	
☐Bleeding Disorders	☐Epilepsy	☐HIV Positive	☐Pneumonia	☐Tuberculosis	
☐Breast Lump	☐Glaucoma	☐Kidney Disease	☐Polio	☐Typhoid Fever	
☐Bronchitis	☐Goiter	☐Liver Disease	☐Prostate Problem	☐Ulcers	

MEDICATIONS List Medications you are currently taken	**ALLERGIES** To medications or substances