HEALTH HISTORY

Date: _____

Patient Name: _____ **Birthdate:** _____ **Patient #** _____

Chief Complaint: _____

History of present illness:

Location: _____
(Where is the pain/ problem?)

Quality: _____
(Example normal versus abnormal color, activity, etc.)

Severity: _____
(How severe is the pain/ problem on scale of 1-5 with 5 being the most severe?)

Duration: _____
(How long have you had the pain/ problem or When did it start?)

Timing: _____
(Does the pain/ problem occur at a specific time?)

Context: _____
(Where, were you at the onset of this pain/ problem?)

Associated signs/symptoms: _____
(What other associated problems have you been having?)

Modifying factors: _____
(What makes the pain/ problem worse or better or Have you had previous episodes?)

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles . . . . . no yes	Anemia . . . . . no yes	Back trouble . . . . . no yes	Heartburn . . . . . no yes
Mumps . . . . . no yes	Bladder Infection . . . . . no yes	High blood pressure . . . . no yes	Gastritis . . . . . no yes
Chickenpox . . . . . no yes	Seizure . . . . . no yes	Low blood pressure . . . . no yes	Kidney Disease . . . . . no yes
Whooping Cough . . . . . no yes	Migraine Headaches . . . no yes	Hemorrhoids . . . . . no yes	Thyroid Disease . . . . no yes
Scarlet Fever . . . . . no yes	Tuberculosis . . . . . no yes	Asthma . . . . . no yes	Bleeding Tendency . . no yes
Diphtheria . . . . . no yes	Diabetes . . . . . no yes	Eczema . . . . . no yes	Any other disease . . . no yes
Smallpox . . . . . no yes	Cancer . . . . . no yes	AIDS or HIV+ . . . . . no yes	(please list): _____
Pneumonia . . . . . no yes	Polio . . . . . no yes	Infectious Mono . . . . . no yes	_____
Rheumatic Fever . . . . . no yes	Glaucoma . . . . . no yes	Bronchitis . . . . . no yes	_____
Heart Disease . . . . . no yes	Hernia . . . . . no yes	Mitral Valve Prolapse . . . no yes	_____
Arthritis . . . . . no yes	Blood or Plasma	Stroke . . . . . no yes	_____
Sexually Transmitted	Transfusions . . . . . no yes	Hepatitis . . . . . no yes	_____
Infection . . . . . no yes			

Previous Hospitalization/ Surgeries/ Serious Illness When? Hospital, City, State

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medications: (include nonprescription) _____

_____

_____

Patient social history:

Martial Status Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Use of alcohol: Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of tobacco: Never: _____ Previously, but quite: _____ Current packs/ day: _____

Use of drugs: Never: _____ Type/ frequency: _____

Excessive exposure at home or work to: Fumes: _____ Dust: _____ Air-borne Solvents: _____ Particles: _____ Noise: _____

Family medical history:

	AGE	Significant Health Problem	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

HEALTH HISTORY

Review of Systems: Please indicate any recent personal history of the items below:

Constitutional Symptoms
- Good general health lately ..... no yes
- Recent weight change ..... no yes
- Fever ..... no yes
- Fatigue ..... no yes
- Headaches ..... no yes

Eyes
- Eyes disease or injury ..... no yes
- Wear glasses / contact lenses ..... no yes
- Blurred or double vision ..... no yes

Ears/ Nose/ Mouth/ Throat
- Hearing loss or ringing ..... no yes
- Earaches or drainage ..... no yes
- Chronic sinus problem or rhinitis ..... no yes
- Nose bleeds ..... no yes
- Mouth sores ..... no yes
- Bleeding gums ..... no yes
- Bad breath or bad taste ..... no yes
- Sore throat or voice change ..... no yes
- Swollen glands in neck ..... no yes

Cardiovascular
- Heart trouble ..... no yes
- Chest pain or angina pectoris ..... no yes
- Palpitation ..... no yes
- Shortness of breath w/walking or lying flat ..... no yes
- Swelling of feet, ankles or hands ..... no yes

Respiratory
- Do you have a persistent cough or throat clearing not associated with a know illness (lasting more than 3 weeks)? ..... no yes
- Spitting up blood ..... no yes
- Shortness of breath ..... no yes
- Wheezing ..... no yes

Gastrointestinal
- Loss of appetite ..... no yes
- Changing in bowel movements ..... no yes
- Nausea or vomiting ..... no yes
- Frequent diarrhea ..... no yes
- Painful bowel movements or constipation no yes
- Rectal bleeding or blood in stool ..... no yes
- Abdominal pain ..... no yes
- Frequent heartburn ..... no yes

Genitourinary
- Frequent urination ..... no yes
- Burning or painful urination ..... no yes
- Blood in urine ..... no yes
- Change in force of stream when urinating ..... no yes
- Incontinence or dribbling ..... no yes
- Kidney stones ..... no yes
- Sexual difficulty ..... no yes
- Male-testicle pain ..... no yes
- Female- pain with periods ..... no yes
- Female- irregular periods ..... no yes
- Female- vaginal discharge ..... no yes
- Female- # of pregnancies .... _____
- Female- # of miscarriage .... _____
- Female- date of last pap smear _____

Musculoskeletal
- Joint pain ..... no yes
- Joint stiffness or swelling ..... no yes
- Weakness of muscles/ joints ... no yes
- Muscle pain or cramps ..... no yes
- Back pain ..... no yes
- Cold extremities ..... no yes
- Difficulty in walking ..... no yes

Integumentary (skin, breast)
- Rash or itching ..... no yes
- Change in skin color ..... no yes
- Change in hair or nails ..... no yes
- Varicose veins ..... no yes
- Breast pain ..... no yes
- Breast lump ..... no yes
- Breast discharge ..... no yes

Neurological
- Frequent or recurring headaches no yes
- Light headed or dizzy ..... no yes
- Convulsions or seizures ..... no yes
- Numbness or tingling sensations no yes
- Tremors ..... no yes
- Paralysis ..... no yes
- Head Injury in your life ..... no yes

Psychiatric
- Memory loss or confusion ..... no yes
- Nervousness ..... no yes
- Depression ..... no yes
- Insomnia ..... no yes

Endocrine
- Glandular or hormone problem ... no yes
- Excessive thirst or urination ..... no yes
- Heat or cold intolerance ..... no yes
- Skin becoming dryer ..... no yes
- Change in hat or gloves size ..... no yes

Hematologic/ Lymphatic
- Slow to heal after cuts ..... no yes
- Bleeding or brushing tendency ... no yes
- Anemia ..... no yes
- Phlebitis ..... no yes
- Past transfusion ..... no yes
- Enlarge glands ..... no yes

Allergic/ Immunologic

History of skin reaction or other adverse reaction to:
- Penicillin or other antibiotics no yes
- Morphine, Demerol, or other narcotics ..... no yes
- Novocain or other anesthetics no yes
- Aspirin or other pain remedies no yes
- Tetanus antitoxin or other serums ..... no yes
- Iodine, Mentholate or other antiseptic ..... no yes
- Other drugs/ medications: _____

_____

_____

Known food allergies: _____

_____

_____

Environmental allergies: _____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

_____ _____

Signature of Patient, Parent or Guardian Date

Doctor's Review

_____ _____

Signature of Doctor Date