

HEALTH HISTORY

Patient Name _____ Birthdate _____ Date _____

Chief Complaint: _____

History of Present Illness:

Location _____
(Where is the pain/problem?)

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

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

Duration _____
(How long have you had this 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?)

Past Medical History

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

Measles.....no yes	Anemia.....no yes	Back trouble.....no yes	Hepatitis.....no yes
Mumps.....no yes	Bladder Infections.....no yes	High Blood Pressure... no yes	Ulcer.....no yes
Chickenpox.....no yes	Epilepsy.....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 Feber.....no yes	Tuberculosis.....no yes	Date of last x-ray_____	Bleeding tendency....no yes
Diphtheria.....no yes	Diabetes.....no yes	Asthma.....no yes	Any other disease....no yes
Smallpox.....no yes	Cancer.....no yes	Hives or Eczema.....no yes	(please list): _____
Pneumonia.....no yes	Polio.....no yes	AIDS or HIV+.....no yes	_____
Rheumatic Fever...no yes	Glaucoma.....no yes	Infectious Mono.....no yes	_____
Heart Disease.....no yes	Hernia.....no yes	Bronchitis.....no yes	_____
Arthritis.....no yes	Blood or Plasma	Mitral Valve Prolapse..no yes	_____
Venereal Disease..no yes	Transfusions.....no yes	Stroke.....no yes	_____

Previous Hospitalizations / Surgeries / Serious Illnesses	When	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications (include nonprescription) _____

Patient Social History:

Marital status Single _____ Married _____ Partner _____ Separated _____ Divorced _____ Widowed _____

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

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

Use of drugs: Never _____ Type / Frequency: _____

Excessive exposure at home or at work to:

Fumes: _____ Dust: _____ Solvents: _____ Airborne particles: _____ Noise: _____

Family Medical History:

Age	Diseases	If Deceased, Cause of Death
Father _____	_____	_____
Mother _____	_____	_____
Siblings _____	_____	_____
_____	_____	_____
_____	_____	_____
Spouse _____	_____	_____
Children _____	_____	_____
_____	_____	_____

Review of Systems: Please indicate any personal history below:

Constitutional Symptoms

Good general health lately..... No Yes
Recent weight change..... No Yes
Fever..... No Yes
Fatigue..... No Yes
Headaches No Yes

Eyes

Eye 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 problems 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 No Yes
 or lying flat No Yes
Swelling of feet, ankles, or hands No Yes

Respiratory

Chronic or frequent coughs No Yes
Spitting up blood No Yes
Shortness of breath No Yes
Wheezing No Yes

Gastrointestinal

Loss of appetite No Yes
Change 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

Genitourinary

Frequent urination..... No Yes
Burning or painful urination..... No Yes
Blood in urine..... No Yes
Change in force of stream No Yes
when urinating..... No Yes
Incontinence or dribbling..... No Yes
Kidney stones No Yes
Sexual difficulty No Yes
Male – testicle pain..... No Yes
Female – pain w/periods..... No Yes
Female – irregular periods No Yes
Female – vaginal discharge..... No Yes
Female - # of pregnancies.....
Female - # of miscarriages
Female – date of last pap smear _____

Musculoskeletal

Joint pain No Yes
Joint stiffness or swelling No Yes
Weakness of muscles or 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 No Yes
Tremors No Yes
Paralysis No Yes
Head injury 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 glove size..... No Yes

Hematologic/Lymphatic

Slow to heal after cuts..... No Yes
Bleeding or bruising tendency No Yes
Anemia..... No Yes
Phlebitis No Yes
Past transfusions No Yes
Enlarged glands No Yes

Allergic/Immunologic

History of skin reaction or other adverse
reaction to:

Penicillin or other antibiotic No Yes
Morphine, Demerol,
or other narcotics No Yes
Novocain or other anesthetic No Yes
Aspirin or other pain drugs No Yes
Tetanus antitoxin
or other serums No Yes
Iodine, Merthiolate 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. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient, Parent or Guardian

Date