

# HEALTH HISTORY

Confidential

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Date of last physical examination \_\_\_\_\_

What is your reason for visit? \_\_\_\_\_

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

### GENERAL

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

### MUSCLE/JOINT/BONE

- Pain, weakness, numbness in:
- Arms
  - Back
  - Feet
  - Hands
  - Hips
  - Legs
  - Neck
  - Shoulders

### GENITO-URINARY

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

### GASTROINTESTINAL

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

### CARDIOVASCULAR

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

### EYE, EAR, NOSE, THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision - Flashes
- Vision - Halos

### SKIN

- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sore that won't heal

### MEN only

- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other

### WOMEN only

- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other

Date of last menstrual period \_\_\_\_\_

Date of last Pap Smear \_\_\_\_\_

Have you had a mammogram? \_\_\_\_\_

Are you pregnant? \_\_\_\_\_  
Number of children \_\_\_\_\_

## CONDITIONS Check (✓) conditions you have or have had in the past.

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

## MEDICATIONS List medications you are currently taking.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone \_\_\_\_\_

## ALLERGIES To medications or substances

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\_\_\_\_\_

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\_\_\_\_\_

