



Health History (Confidential)

Name _____

Today's Date _____

Age _____ Birthdate: _____

Date of last physician examination _____

What is your reason for today's visit? _____

SYMPTOMS Check () symptoms you currently have or have had in the past.					
GENERAL		GASTROINTESTINAL		EYE, EAR, NOSE, THROAT	HEALTH HABITS
<input type="checkbox"/> Chills	<input type="checkbox"/>	<input type="checkbox"/> Appetite poor	<input type="checkbox"/>	<input type="checkbox"/> Bleeding gums	Check if applies to you:
<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/> Abdomen/Pelvic Pain	<input type="checkbox"/>	<input type="checkbox"/> Blurred vision	Caffeine / Yes ___ No ___
<input type="checkbox"/> Dizziness	<input type="checkbox"/>	<input type="checkbox"/> Bloating	<input type="checkbox"/>	<input type="checkbox"/> Crossed eyes	How Much?
<input type="checkbox"/> Falls	<input type="checkbox"/>	<input type="checkbox"/> Bowel changes	<input type="checkbox"/>	<input type="checkbox"/> Difficulty Speaking	Tobacco / Yes ___ No ___
<input type="checkbox"/> Fainting	<input type="checkbox"/>	<input type="checkbox"/> Constipation	<input type="checkbox"/>	<input type="checkbox"/> Difficulty swallowing	How Much?
<input type="checkbox"/> Fever	<input type="checkbox"/>	<input type="checkbox"/> Diarrhea	<input type="checkbox"/>	<input type="checkbox"/> Double vision	Drugs / Yes ___ No ___
<input type="checkbox"/> Memory Loss	<input type="checkbox"/>	<input type="checkbox"/> Excessive hunger	<input type="checkbox"/>	<input type="checkbox"/> Earache	How Much?
<input type="checkbox"/> Headache	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/> Ear drainage	Alcohol / Yes ___ No ___
<input type="checkbox"/> Loss of Balance	<input type="checkbox"/>	<input type="checkbox"/> Gas	<input type="checkbox"/>	<input type="checkbox"/> Hay fever	How much per week?
<input type="checkbox"/> Loss/Gain of weight	<input type="checkbox"/>	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/> Sore Throat	_____
<input type="checkbox"/> Nervousness	<input type="checkbox"/>	<input type="checkbox"/> Indigestion/Heartburn	<input type="checkbox"/>	<input type="checkbox"/> Loss of hearing	Exercise / Yes ___ No ___
<input type="checkbox"/> Numbness	<input type="checkbox"/>	<input type="checkbox"/> Nausea	<input type="checkbox"/>	<input type="checkbox"/> Nosebleeds	How Often? _____
<input type="checkbox"/> Sweats	<input type="checkbox"/>	<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/>	<input type="checkbox"/> Persistent cough	MEN only
<input type="checkbox"/> Trouble Sleeping	<input type="checkbox"/>	<input type="checkbox"/> Stomach pain	<input type="checkbox"/>	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Breast lump
		<input type="checkbox"/> Vomiting	<input type="checkbox"/>	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Erection difficulties
		<input type="checkbox"/> Vomiting blood	<input type="checkbox"/>	<input type="checkbox"/> Sores	<input type="checkbox"/> Lump in testicles
MUSCLE, JOINT, BONE			CARDIOVASCULAR	<input type="checkbox"/> Vision - Flashes/Halos	<input type="checkbox"/> Penis discharge
Pain, weakness, numbness, tingling, Stiffness:		<input type="checkbox"/> Chest pain			<input type="checkbox"/> Sore on penis
<input type="checkbox"/> Arms	<input type="checkbox"/> Hips	<input type="checkbox"/> Heart Murmurs		SKIN	<input type="checkbox"/> Prostate Problem
<input type="checkbox"/> Back	<input type="checkbox"/> Legs	<input type="checkbox"/> High blood pressure		<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Prostate Exam
<input type="checkbox"/> Feet	<input type="checkbox"/> Neck	<input type="checkbox"/> Irregular heart beat		<input type="checkbox"/> Hives	<input type="checkbox"/> Colonoscopy
<input type="checkbox"/> Hands	<input type="checkbox"/> Shoulders	<input type="checkbox"/> Low blood pressure		<input type="checkbox"/> Itching	<input type="checkbox"/> Other _____
GENITO-URINARY		<input type="checkbox"/> Poor circulation		<input type="checkbox"/> Change in moles	WOMEN only
<input type="checkbox"/> Blood in urine		<input type="checkbox"/> Swelling of ankles		<input type="checkbox"/> Rash	<input type="checkbox"/> Abnormal Pap Smear
<input type="checkbox"/> Frequent urination		<input type="checkbox"/> Varicose veins		<input type="checkbox"/> Scars	<input type="checkbox"/> Bleeding between periods
<input type="checkbox"/> Lack of bladder control				<input type="checkbox"/> Sore that won't heal	<input type="checkbox"/> Breast lump
<input type="checkbox"/> Painful urination					<input type="checkbox"/> Decrease Sex Drive
CONDITIONS Check () conditions you have or have had in the past.					<input type="checkbox"/> Extreme menstrual pain
<input type="checkbox"/> ADHD/ADD	<input type="checkbox"/>	<input type="checkbox"/> Emphysema	<input type="checkbox"/>	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Hot flashes
<input type="checkbox"/> Alcoholism	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy	<input type="checkbox"/>	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Miscarriages
<input type="checkbox"/> Anemia	<input type="checkbox"/>	<input type="checkbox"/> Glaucoma	<input type="checkbox"/>	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Nipple discharge
<input type="checkbox"/> Anorexia	<input type="checkbox"/>	<input type="checkbox"/> Goiter	<input type="checkbox"/>	<input type="checkbox"/> Polio	<input type="checkbox"/> Painful intercourse
<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Gout	<input type="checkbox"/>	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Vaginal discharge/Infection
<input type="checkbox"/> Asthma/COPD	<input type="checkbox"/>	<input type="checkbox"/> Heart Disease	<input type="checkbox"/>	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Are you pregnant? _____
<input type="checkbox"/> Blood Clots	<input type="checkbox"/>	<input type="checkbox"/> Hernia	<input type="checkbox"/>	<input type="checkbox"/> Sexually Transm. Disease	<input type="checkbox"/> Number of children: _____
<input type="checkbox"/> Breast Lump	<input type="checkbox"/>	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/> Number of Pregnancies: _____
<input type="checkbox"/> Bronchitis	<input type="checkbox"/>	<input type="checkbox"/> HIV Positive	<input type="checkbox"/>	<input type="checkbox"/> Suicide Attempt	<input type="checkbox"/> Delivery Complication:
<input type="checkbox"/> Bulimia	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/> Thyroid Problems	Yes ___ No ___
<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> Liver Disease	<input type="checkbox"/>	<input type="checkbox"/> Tonsillitis	Date of last:
Type: _____	<input type="checkbox"/>	<input type="checkbox"/> Measles	<input type="checkbox"/>	<input type="checkbox"/> Tremors	<input type="checkbox"/> Menstrual period _____
<input type="checkbox"/> Cataracts	<input type="checkbox"/>	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Pap Smear _____
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/> Typhoid Fever	<input type="checkbox"/> Mammogram _____
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Bone Density _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Mumps	<input type="checkbox"/>	<input type="checkbox"/> Urinary tract infection	<input type="checkbox"/> Colonoscopy _____



Patient Name: _____

DOB: _____

Health History (Cont.)

Current Medication List:	ALLERGIES to medications or substances
	Latex?

Pharmacy Name: _____ Pharmacy Phone Number: _____

Have you ever had a blood transfusion? Yes No

If Yes, give approximate dates: _____

SERIOUS ILLNESS, INJURIES	DATE	OUTCOME	Your Occupation:
			Employer:

IMMUNIZATION STATUS Date of Last:

Tetanus		Tuberculosis
Flu		Zostavax
Pneumonia		Other Vaccine

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

FAMILY HISTORY

Fill in health information about your family

Who?	What Condition?	Age Of Onset	Cause of Death

Check if your blood relatives had any of the following:

Disease
Arthritis, Gout
Asthma, Hay Fever
Cancer
Chemical Dependency
Diabetes
Heart Disease, Strokes
High Blood Pressure
Kidney Disease
Tuberculosis
Other

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature

Reviewed By

ems07.28.10