

# 5

## HEALTH HISTORY

All information is strictly confidential.

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

### GENERAL

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

### MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

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

### GENITO-URINARY

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

### GASTROINTESTINAL

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

### CARDIOVASCULAR

- Chest pain
- High/Low blood pressure
- Irregular/Rapid heart beat
- Poor circulation
- 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/Halos

### SKIN

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

### MEN only

- 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 \_\_\_\_\_

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

- |  |   |
|--|---|
| <input type="checkbox"/> AIDS                | <input type="checkbox"/> Chicken Pox      |
| <input type="checkbox"/> Appendicitis        | <input type="checkbox"/> Diabetes         |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Emphysema        |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Epilepsy         |
| <input type="checkbox"/> Bleeding Disorders  | <input type="checkbox"/> Glaucoma         |
| <input type="checkbox"/> Breast Lump         | <input type="checkbox"/> Heart Disease    |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Hepatitis        |
| <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Herpes           |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol |

- HIV Positive
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia

- Polio
- Prostate Problem
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers
- Venereal Disease

Describe serious illnesses or operations \_\_\_\_\_

# 6

## MEDICATIONS/ALLERGIES

List medications you are currently taking \_\_\_\_\_

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

Phone (\_\_\_\_) \_\_\_\_\_

List allergies to medications or substances \_\_\_\_\_

# 7

## HEALTH HABITS

Check (✓) which you use and how much:

- Caffeine \_\_\_\_\_
- Street Drugs \_\_\_\_\_
- Tobacco \_\_\_\_\_
- Other \_\_\_\_\_

Check (✓) if your work exposes you to:

- Stress
- Heavy Lifting
- Hazardous Substances
- Other \_\_\_\_\_

# 8

## SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Reviewed By

Date