

(Confidential Health History)

Name _____ **Today's Date** _____

Age _____ **Date of Birth** _____ **Date of last physical examination** _____

What is your reason for today's visit? _____

ILLNESS: Please indicate if you now have or have ever had any of the following illnesses. Please note the year you had the problem or when it started.

ALLERGIES _____	EPILEPSY/SEIZURE _____	PROSTATE _____
ANEMIA _____	GOUT _____	PSYCHIATRIC _____
CHRONIC ANXIETY _____	HEADACHE _____	SINUS PROBLEMS _____
ARTHRITIS _____	HEART DISEASE _____	SKIN CANCER _____
ASTHMA _____	HEPATITIS _____	STROKE _____
BACK PROBLEMS _____	HIGH BLOOD PRESSURE _____	THYROID DISEASE _____
BLEEDING DISORDER _____	HIGH CHOLESTEROL _____	TUBERCULOSIS _____
BRONCHITIS _____	KIDNEY DISEASE _____	ULCERS _____
CANCER (breast, colon) _____	LIVER DISEASE _____	VASCULAR DISEASE/CIRCULATION _____
CATARACTS _____	MIGRAINE _____	_____
DEPRESSION _____	MULTIPLE SCLEROSIS _____	VENEREAL DISEASE (herpes, HIV, etc.) _____
DIABETES _____	OBSTRUCTIVE SLEEP APNEA _____	_____
EMPHYSEMA _____	PNEUMONIA _____	VISION PROBLEMS _____

Other significant illnesses not listed: _____

List any abnormal test (blood, x-rays, etc.): _____

SURGERIES/HOSPITALIZATIONS: Please indicate the year if you had any of the listed surgeries.

APPENDIX _____	CATARACT SURGERY _____	HYSTERECTOMY _____
BREAST BIOPSY _____	COLON/RECTAL SURGERY _____	KIDNEY/BLADDER _____
BREAST MASTECTOMY _____	HERNIA SURGERY _____	TONSILS _____
C-SECTION _____	KNEE SURGERY _____	TUBAL LIGATION _____
CARDIAC SURGERY _____	SHOULDER SURGERY _____	TUBES IN EARS _____
D & C _____	GALLBLADDER _____	VASECTOMY _____

Please list any other significant surgeries (back, knee, hip, shoulder, thyroid, etc.) _____

MEDICATIONS YOU ARE TAKING: Please include doses and times taken each day. _____

ALLERGIES TO MEDICATIONS: Please also describe your allergic reaction. _____

Patient Name _____ DOB _____

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IMMUNIZATIONS AND PREVENTION (Please check and list the date you last had, if any.)

Tetanus _____ TB skin test _____ PAP smear _____
Influenza vaccine _____ Hearing test _____ Mammogram _____
Pneumonia vaccine _____ Eye exam _____ Bone density _____
Colon cancer test _____ Cholesterol _____ PSA test _____
Upper endoscopy _____ Shingles vaccine _____

FAMILY HISTORY

	Alive	Dead	Age	Chronic Health Problems/Cause of Death
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Brothers (#)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sisters (#)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
B or S	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
B or S	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Children (#)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Please check all the health problems in your relatives, and note which relative is affected:

Who?	Who?
Bleeding problems _____	High Blood pressure _____
Cancer, breast _____	Kidney Disease _____
Cancer, colon _____	Liver Disease _____
Cancer _____	Mental Disease _____
Diabetes _____	Seizures _____
Glaucoma _____	Stroke _____
Heart disease _____	Thyroid Problems _____
Other _____	Other _____

SOCIAL & PERSONAL HISTORY

Answering these confidential questions honestly will allow an accurate assessment of your health risks. If you are uncomfortable with any of the questions, you have the option of not answering it.

Current Occupation: _____

Education Completed: _____ Where Born: _____

Marital Status: _____ Single _____ Married (Year _____) _____ Widowed (Year _____) _____ Separated (Year _____)
_____ Divorced (Year _____)

Married: _____ times: 1st _____ yrs, _____ children 2nd _____ yrs, _____ children 3rd _____ yrs, _____ children

I Live With: _____

Currently use tobacco _____ Cigarette _____ Cigar _____ Pipe _____ Chew Amount/day: _____ Years: _____

Former smoker _____ Amount/day: _____ Years: _____ Quit date: _____ 2nd hand smoke exposure _____

Consume Alcohol _____ Type: _____ Amount/day: _____ or/week: _____

Use recreational drugs _____ Type: _____ Frequency: _____

Have ever used needles to inject drugs _____

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Consume caffeine beverage: ___ Amount/day _____

Exercise regularly ___ Type: _____ Frequency/week _____

Use sunscreen ___ Take calcium supplements ___ Wear my seatbelt ___

Have had blood transfusions ___ Year: ___ Have tattoos _____

Sexual History: Are you sexually active? ___ Yes ___ No ___ Not currently

My sexual partner(s) is/are ___ male ___ female was/were ___ male ___ female

History of sexually transmitted diseases? ___ Yes ___ No

Use contraception ___ Type: _____

REVIEW OF SYSTEMS

General

None apply

___ Significant weight loss ___ Fatigue or loss of energy ___ Difficulty sleeping ___ Loss of feeling or well being

Comments: _____

Eyes

None Apply

___ Blurred vision ___ Double vision ___ Spots in front of eyes ___ Eye pain/irritation

___ Need for corrective lens

Comments: _____

Ear-Nose-Throat

None Apply

___ Chronic Headaches ___ Hearing loss ___ Ringing in ears ___ Dizziness ___ Ear pressure

___ Chronic nasal congestion ___ Recurrent sinus infections ___ Nose bleeds ___ Constant runny nose

___ Bleeding gums ___ Sore throat ___ Toothaches ___ Sores in mouth ___ Breath odor ___ Hoarseness

Comments: _____

Cardiovascular

None Apply

___ Chest pain ___ Heart racing ___ Heart palpitations ___ Heart murmur

___ Decreased exercise tolerance ___ Difficulty breathing when lying down

___ Awakening because of short of breath ___ Leg Swelling

___ Pain in back of legs or buttocks with exercise, better with rest

___ Sensitivity of hand/feet to temperature

Comments: _____

Respiratory

None Apply

___ Shortness of breath ___ Cough ___ Chest Congestion ___ Wheezing ___ Noisy breathing

___ Choking ___ Coughing up blood ___ History of tuberculosis(TB) ___ History of pneumonia

Comments: _____

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Breast

None Apply

___ Breast lump ___ Breast pain ___ Nipple discharge ___ Skin changes

___ If Female, perform monthly self exams

Comments: _____

Gastrointestinal

None Apply

___ Stomach pains ___ Nausea ___ Vomiting ___ Diarrhea ___ Constipation

___ Difficulty swallowing ___ Frequent heartburn ___ Indigestion ___ Belching/burping

___ Sour taste in mouth ___ Bloating ___ History of yellow jaundice ___ History of hepatitis

___ History of ulcers ___ History of colon polyps ___ Rectal bleeding ___ Rectal pain or irritation

___ Swelling/ bumps or hemorrhoids ___ Black, tarry stools

Comments: _____

Endocrine

None Apply

Unexpected changes in: ___ Tolerance to heat ___ Tolerance to cold ___ Unusual thirst ___ Hair loss

Comments: _____

Genitourinary (men)

None Apply

___ Frequent urination (___ often at night) ___ Frequent urge to urination ___ Pain on urination

___ Blood in urine ___ Trouble Starting urination ___ Interruption of urine stream ___ Dribbling

___ Loss of bladder control ___ Pain swelling of penis ___ Discharge of penis

___ Pain/swelling/lump in Scrotum ___ Pain/swelling in groin ___ Decline in sexual desire

___ Difficulty having erections ___ Difficulty maintaining erections/reaching climax

Comments: _____

Genitourinary (Women) Last period _____

None Apply

___ Frequent urination ___ Frequent urge to urination ___ Pain on urination ___ Blood in urine

___ Frequent urinary infections ___ Frequent loss of urination ___ Hot flashes ___ Pressure in vagina

___ Vaginal irritation ___ Vaginal dryness ___ Vaginal discharge ___ Vaginal pain

___ Painful intercourse ___ Decline in sexual desire ___ Difficulty in sexual response

___ Inability to orgasm ___ Bleeding between periods ___ Irregular periods

___ Change in periods (flow/frequency) ___ PMS or troublesome symptoms before/during period

___ Pelvic pain ___ Took infertility medication ___ Taking hormone replacement

___ Abnormal PAP smear ___ Have had sexually transmitted disease

Age periods began ___ Periods occur every ___ days with light/med/heavy flow

Number pregnancies ___ Number of deliveries ___ Number of miscarriages/abortions ___

Comments: _____

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Lymphatic and Hematologic

None Apply

Unusual lymph node swelling (neck, armpit, groin) Painful lymph nodes
 History of anemia or low blood count Blood clots Easy bruising Unusual bleeding

Comments: _____

Musculoskeletal

None Apply

Limb or joint pains Limb or joint deformity Limb or joint swelling/stiffness/redness
 Muscle weakness Loss of muscle bulk Muscle spasm or twitching Muscle aching
 Recurring back or neck pain Back or neck injury

Comments: _____

Neurologic and psychologic

None Apply

Seizures Stroke Tremors Unusual clumsiness Limb weakness
 Numbness/tingling History of significant head injury Altered consciousness or black outs
 Dizziness Frequent headaches History of migraine Previous diagnosis of dementia
 Lapse in memory Periods of disorientation/confusion Difficulty concentrating
 Troublesome depression Worry about things Mood swings History of mental illness
 Unusual stress History of physical abuse History of mental abuse or mental trauma
 Thoughts of hurting self or others Panic attacks Anxiety

Comments: _____

Skin

None Apply

Rash Itching Unusual dryness Changes in pigmentation

Comments: _____

Allergy/Immunologic

None Apply

Seasonal allergics Sensitivity to specific items Frequent or unusual infections Fever

Comments: _____