



# HEALTH HISTORY

Please complete the following information for review by your provider.

Name: \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Race: \_\_\_\_\_ Sex:  M  F Dominant Hand:  Right  Left  
 Referring Doctor: \_\_\_\_\_ Family Doctor: \_\_\_\_\_ Occupation: \_\_\_\_\_

## Patient Medical History

- |   |                                      |   |                                       |                                    |
|---|--------------------------------------|---|---------------------------------------|------------------------------------|
| <input type="radio"/> Heart Trouble       | <input type="radio"/> Gout           | <input type="radio"/> Bleeding Problems | <input type="radio"/> Anemia          | <input type="radio"/> AIDS/HIV     |
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Seizures       | <input type="radio"/> Serious Injuries  | <input type="radio"/> Stomach Ulcers  | <input type="radio"/> Hepatitis    |
| <input type="radio"/> Stroke              | <input type="radio"/> Sleep Apnea    | <input type="radio"/> Lung Disease      | <input type="radio"/> Liver Trouble   | <input type="radio"/> Other: _____ |
| <input type="radio"/> Diabetes            | <input type="radio"/> Kidney Trouble | <input type="radio"/> Asthma            | <input type="radio"/> Thyroid Trouble | _____                              |
| <input type="radio"/> Arthritis           | <input type="radio"/> Osteoporosis   | <input type="radio"/> Phlebitis         | <input type="radio"/> Cancer          | _____                              |

Previous Surgeries: <input type="checkbox"/> None	Hospital/Date	Previous Surgeries:	Hospital/Date
1.		4.	
2.		5.	
3.		6.	

## Family Medical History (Mark if any of these run in your family)

- |   |                                |                                 |                                      |                                      |                                  |
|---|--------------------------------|---------------------------------|--------------------------------------|--------------------------------------|----------------------------------|
| <input type="radio"/> Heart Trouble       | <input type="radio"/> Stroke   | <input type="radio"/> Arthritis | <input type="radio"/> Seizures       | <input type="radio"/> Kidney Trouble | <input type="radio"/> Alcoholism |
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Diabetes | <input type="radio"/> Gout      | <input type="radio"/> Mental Illness | <input type="radio"/> Bleeding       | <input type="radio"/> Cancer     |

## Social History

Married / Single Do you live alone?  Yes  No If no, who do you live with? \_\_\_\_\_  
 # of children: \_\_\_\_\_ Do you exercise regularly?  Yes  No Describe: \_\_\_\_\_  
 Tobacco Use?  Yes  No Type: \_\_\_\_\_ Amount per day \_\_\_\_\_ # of years used: \_\_\_\_\_  
 Alcohol Consumption?  Yes  No # of drinks/week: \_\_\_\_\_ History of Alcoholism?  Yes  No  
 Recreational/Drug Usage:  Yes  No Type/Amount/How Often: \_\_\_\_\_

## Review of Systems (recent or current conditions only)

<input type="radio"/> Weight Change	<input type="radio"/> Ear Pain / Ringing	<input type="radio"/> Shortness of Breath	<input type="radio"/> Incontinence	<input type="radio"/> Numbness
<input type="radio"/> Fever / Chills	<input type="radio"/> Nosebleeds	<input type="radio"/> Cough	<input type="radio"/> Urinary Frequency	<input type="radio"/> Weakness
<input type="radio"/> Night Sweats	<input type="radio"/> Hoarseness	<input type="radio"/> Stomach Pain	<input type="radio"/> Urinary Burning	<input type="radio"/> Frequent Headaches
<input type="radio"/> Poor Appetite	<input type="radio"/> Difficulty Swallowing	<input type="radio"/> Nausea / Vomiting	<input type="radio"/> Irregular Periods	<input type="radio"/> Seizures
<input type="radio"/> Rash	<input type="radio"/> Tooth/Gum Trouble	<input type="radio"/> Frequent Diarrhea	<input type="radio"/> Vaginal Discharge	<input type="radio"/> Blackouts
<input type="radio"/> Insomnia	<input type="radio"/> Visual Changes	<input type="radio"/> Frequent Constipation	<input type="radio"/> Pregnant	<input type="radio"/> Chronic Infection
<input type="radio"/> Depression	<input type="radio"/> Chest Pain	<input type="radio"/> Blood in Stool	<input type="radio"/> Joint/Limb Swelling	<input type="radio"/> _____
<input type="radio"/> Anxiety	<input type="radio"/> Abnormal Heartbeat		<input type="radio"/> Joint Pain	
			<input type="radio"/> Lumps/Masses	
			<input type="radio"/> Backache	

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Notes:

Physician Reviewed:	
Initials: _____	Date: _____
Initials: _____	Date: _____
Initials: _____	Date: _____
Initials: _____	Date: _____

