

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/Jaundice |
| <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"/> CPAP | <input type="radio"/> Asthma <input type="radio"/> Inhaler | <input type="radio"/> Thyroid Trouble | _____ |
| <input type="radio"/> Arthritis | <input type="radio"/> Kidney Trouble | <input type="radio"/> Phlebitis | <input type="radio"/> Cancer | _____ |
| | <input type="radio"/> Osteoporosis | <input type="radio"/> Blood Clots | | |

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)

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

Notes:

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