HEALTH HISTORY **Date:**_____ **Account#**_____

Name: _____ Birthdate: _____

Welcome to our practice. Please answer the following questions to update your medical history.

Chief Complaint: *(What is the main reason for this visit?)*

_____

_____

Present illness:

Location: *(Where is the pain or problem?)*_____

Quality: *(What does it feel like?)* _____

Severity: *(How severe is the pain or problem on a scale of 1-5, 5 being the worse.)* _____

Timing: *(Does the pain/problem occur at a specific time?)*._____

Duration: *(How long have you had this pain/problem? Or when did it start?)* _____

Content: *(Where were you at the onset of this pain/problem?)*. _____

Modifying factors: *(What Makes pain/problem worse or better ?or Have you had previous episodes ?).*

Do you have any other problems you want addressed?

1. _____

2. _____

3. _____

Past Medical History: Have you ever had the following: *(Circle "no" or "yes", leave blank if uncertain)*

Anemia	no	yes	Back trouble	no	yes	Hepatitis	no	yes	High Blood Pressure	no	yes
Asthma	no	yes	Liver disease	no	yes	Epilepsy	no	yes	Low Blood Pressure	no	yes
Kidney disease	no	yes	Diabetes	no	yes	Hemorrhoids	no	yes	Thyroid disease	no	yes
Rheumatic fever	no	yes	Tuberculosis	no	yes	Bladder infections	no	yes	Bleeding problems	no	yes
Ulcer	no	yes	Cancer	no	yes	Migraine Headaches	no	yes	Colon Polyps	no	yes
Pneumonia	no	yes	Hives or Eczema	no	yes	Glaucoma	no	yes	Heart disease	no	yes
Bronchitis	no	yes	AIDS or HIV	no	yes	Venereal disease	no	yes	Mitral valve Prolapse	no	yes
Stroke	no	yes	Arthritis	no	yes	Blood Transfusion.	no	yes			

Have you ever had a colonoscopy (colon exam)?_____

MEN: Last PSA→ Women: Last mammogram→ Last PAP smear→

Previous Hospitalizations:

Surgeries /Serious illnesses	When?	Hospital,	City, State
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Social **history**: Marital status: Single:____ Married:____ Separated:____ Divorced:____ Widowed:____

Alcohol use: Never: ____ Rarely: ____ Moderate:____ Daily: ____

Smoking: Never: ____ Previous, but quit: _____ Currently smoke packs per day: _____

Use of Drugs: Never: ____ Type/Frequency:_____/_____

HEALTH HISTORY

Date:_____ **Account#**_____

Family Medical History:

	AGE	Diseases	If deceased, cause of death.
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	_____	_____	_____

Review of Systems: Please indicate if you have had any of the following symptoms: (Circle "no" or "yes")

Constitutional symptoms

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes

Eyes

	No	Yes
Eye disease or injury	No	Yes
Wear glasses or contacts	No	Yes
Blurred or double	No	Yes

Ears/Nose/Throat

Hearing loss	No	Yes
Ringing in ears	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problems	No	Yes
Chronic nasal congestion	No	Yes
Nosebleeds	No	Yes
Mouth sores	No	Yes
Bad breath or bad taste	No	Yes
Sore throat	No	Yes
Swollen gland in neck	No	Yes

Cardiovascular

Heart trouble	No	Yes
Chest pain or angina	No	Yes
Palpitations	No	Yes
Shortness of Breath (SOB)	No	Yes
SOB while lying flat	No	Yes
SOB while walking	No	Yes
Swelling in feet or legs	No	Yes

Gastrointestinal

Abdominal pain	No	Yes
Nausa or vomiting	No	Yes
Constipation	No	Yes
Loss of appetite	No	Yes
Dark Black stools	No	Yes
Blood in stool	No	Yes
Frequent diarrhea	No	Yes

Genitourinary

Frequent urination	No	Yes
Pain with urination	No	Yes
Blood in urine	No	Yes
Difficulty urinating	No	Yes
Urinary Incontinence	No	Yes
Dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Male–testicular pain	No	Yes
Testicular knot or swelling	No	Yes
Female-pain with periods	No	Yes
Female-Irregular periods	No	Yes
Female-vaginal discharge	No	Yes
Female-# of pregnancies	No	Yes
Female-# of miscarriages	No	Yes
Date of last pap smear:_____		

Musculoskeletal

Joint pain or stiffness	No	Yes
joint swelling	No	Yes
Difficulty walking	No	Yes
Muscle pain or cramps	No	Yes
Back Pain	No	Yes

Dermatological

Rash or excessive itching	No	Yes
Change in hair or nails	No	Yes
Varicose Veins	No	Yes
Breast Lump	No	Yes
Breast discharge	No	Yes
Breast Pain	No	Yes

Respiratory

Chronic/Frequent cough	No	Yes
Wheezing	No	Yes
Pain with deep breath	No	Yes
Shortness of breath	No	Yes
Spitting up blood	No	Yes

Psychiatric

Memory loss or confusion	No	Yes
Anxiety or nervousness	No	Yes
Depression	No	Yes
Difficulty sleeping	No	Yes

Endocrine

Glandular or hormone problem	No	Yes
Excessive thirst or Urination	No	Yes
Heat or cold intolerance	No	Yes

Hematologic/Lymphatic

Slow to heal after cuts	No	Yes
Bleeds or bruises easily	No	Yes
Anemia	No	Yes
Blood clots	No	Yes
Past hx of transfusion	No	Yes
Enlarged glands	No	Yes

Allergic/Immunologic

History of skin reaction or other adverse reaction to:		
Penicillin or other antibiotics	No	Yes
Demerol or other narcotic	No	Yes
Novocaine or other anesthetic	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus shot	No	Yes
Iodine	No	Yes

Neurological

Lightheaded or dizziness	No	Yes
Frequent or recurring headaches	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
History of Head injury	No	Yes
Tremors	No	Yes
Paralysis	No	Yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's of any changes in my medical status, I also authorize the healthcare staff to perform the necessary services I may need.

Doctor's Review

_____ _____ _____ _____

Signature of Patient, Parent or Guardian | Date | Signature of Doctor | Date