HEALTH H	ISTORY		Date:_		Account#	
Name:			3,042	Birthdate:		
Welcome to o	our practice. l	Please answer the f	ollowing question	ns to update you	Constitution and	
		the main reason fo			ieder:	
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Present illne						
Location: (W	here is the pa	in or problem?)_		Hal Madaat	e dat estimat beskin 1965 g No. Yes	
Quality: (Who	at does it feel	like?)	V/I 5	that the back!	37 37	
Severity: (Ho	w severe is th	ne pain or problem	on a scale of 1-5	, 5 being the wor	rse.)	
					2005 No. 700 Yes	
					est of transport medians.	
		at the onset of this				
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Have you ever MEN: Last PS Previous Hos Surgeries /Ser	SA→ pitalizations	votell 67	m)?ast mammogram Hospital,	> riiqa.5	Last PAP smear-> City, State	
Social history Alcohol use: Smoking: Use of Drugs:	Never:	NAME OF THE OWNER OWNER OWNER OF THE OWNER OWNE	nit:	_ Daily:	Divorced: Widowed:	

SOB while lying flat No Yes Varicose Veins No Yes SOB while walking No Yes Breast Lump No Yes Swelling in feet or legs No Yes Breast Pain No Yes Respiratory No Yes Convulsions or seizures No Yes Numbness or tingling sensations No Yes Convulsions or seizures No Yes Numbness or tingling sensations No Yes Convulsions or seizures No Yes Numbness or tingling sensations No Yes No Yes No Yes No Yes Convulsions or seizures No Yes Numbness or tingling sensations No Yes No Y	Fourth M. H. Lyr.			Date:			Account#		
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Breast Pain No Yes Breast Pain No Yes Lightheaded or dizziness No Yes Frequent or recurring headaches No Yes Convulsions or seizures No Yes Numbness or tingling sensations No Yes Constipation No Yes Wheezing No Yes Dark Black stools No Yes Shortness of breath No Yes Blood in stool No Yes Spitting up blood 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.							Neurological		
Abdominal pain No Yes Respiratory Nausa or vomiting No Yes Chronic/Frequent cough No Yes Unumbness or tingling sensations No Yes Constipation No Yes Wheezing No Yes Tremors No Yes Dark Black stools No Yes Shortness of breath No Yes Blood in stool No Yes Spitting up blood 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.	2	110	103					No	Ves
Abdominal pain No Yes Respiratory Nausa or vomiting No Yes Chronic/Frequent cough No Yes Numbness or tingling sensations No Yes Constipation No Yes Wheezing No Yes Tremors No Yes Dark Black stools No Yes Shortness of breath No Yes Paralysis No Yes Blood in stool No Yes Spitting up blood 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.	Gastrointestinal			Breast I am	NO	Yes		No	
Nausa or vomiting No Yes Chronic/Frequent cough No Yes Wheezing No Yes Wheezing No Yes Tremors No Yes Dark Black stools No Yes Shortness of breath No Yes Blood in stool No Yes Frequent diarrhea 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.		No	Vec	Dominate			Convulsions or seizures		
Constipation No Yes Wheezing No Yes History of Head injury No Yes Loss of appetite No Yes Pain with deep breath No Yes Paralysis No Yes Dark Black stools No Yes Shortness of breath No Yes Paralysis No Yes Blood in stool No Yes Spitting up blood No Yes Frequent diarrhea 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.									
Loss of appetite No Yes Pain with deep breath No Yes Paralysis No Yes Dark Black stools No Yes Shortness of breath No Yes Paralysis No Yes Blood in stool No Yes Spitting up blood No Yes Frequent diarrhea 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.							History of Head injury		
Dark Black stools No Yes Shortness of breath No Yes Blood in stool No Yes Spitting up blood No Yes Frequent diarrhea 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.									
Blood in stool No Yes Spitting up blood No Yes Frequent diarrhea 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.							Paralysis		
Frequent diarrhea 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.									
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.				Spitting up blood	NO	Yes			
I also authorize the healthcare staff to perform the necessary services I may need.				on this fam. 1					
I also authorize the healthcare staff to perform the necessary services I may need.	information can be dangero	ue to	my boolst	It is many mave been acc	curate	ely answ	ered. I understand that providing i	ncor	rect
and the hearthcare start to perform the necessary services I may need.	the sent of duligoid	us to	my meanur	. It is invites nonstrainty to it	ntorn	the doo	tor's of any changes in my medica	l sta	tus,
Doctor's Review	and administrating like likelings	are sta	ii to perfo	in the necessary services I	may	need.			
				Docto	or's R	Review			
Signature of Patient, Parent or Guardian Date Signature of Doctor									