Health History

Date: _____

Patient Name: _____ Birthdate: _____

Chief Complaint: _____

History of present illness:

Location: _____
Where is the pain/problem?

Quality: _____
Example: normal vs. abnormal color, activity, etc.

Severity: _____
How severe is the pain/problem on a scale of 1 - 5 with 5 being most severe?

Duration: _____
How long have you had this pain/problem?, or When did it start?

Timing: _____
Does the pain/problem occur at a specific time?

Context: _____
Where were you at the onset of this pain/problem?

Associated signs/symptoms: _____
What other associated problems have you been having?

Modifying Factors: _____
What makes the pain/problem worse or better?. or. Have you had a previous episode?

Past Medical History

Have you ever had the following: Circle "no" or "yes," leave blank if uncertain.

Measles	no	yes	Venereal Disease	no	yes	Back trouble	no	yes	Hepatitis	no	yes
Mumps	no	yes	Anemia	no	yes	High blood pressure	no	yes	Kidney Disease	no	yes
Chickenpox	no	yes	Bladder Infections	no	yes	Low blood pressure	no	yes	Thyroid Disease	no	yes
Whooping cough	no	yes	Epilepsy	no	yes	Hemorrhoids	no	yes	Bleeding Tendency	no	yes
Scarlet fever	no	yes	Migraine Headaches	no	yes	Asthma	no	yes	Blood / Plasma Transfusion	no	yes
Diphtheria	no	yes	Tuberculosis	no	yes	Hives or Eczema	no	yes	Date of last chest x-ray		
Smallpox	no	yes	Diabetes	no	yes	Aids or HIV	no	yes	Any other disease	no	yes
Pneumonia	no	yes	Cancer	no	yes	Infectious Mono	no	yes	please list		
Rheumatic Fever	no	yes	Polio	no	yes	Bronchitis	no	yes			
Heart Disease	no	yes	Glaucoma	no	yes	Mitral Valve Prolaspe	no	yes			
Arthritis	no	yes	Hernia	no	yes	Stroke	no	yes			

Previous Hospitalizations / Surgeries / Serious Illnesses **When** **Hospital, City, State**

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medications: (Include nonprescription) _____

_____

_____

Patient social history:

Marital Status ..... Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Use of alcohol ..... Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of tobacco ..... Never: _____ Previously, but quit: _____ Current packs / day: _____

Use of drugs ..... Never: _____ Type / Frequency _____

Excessive exposure at home or work to .... Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

Family medical history:

	Age	Diseases	If deceased, cause of death
Father			
Mother			
Siblings			
Spouse			
Children			

Review of Systems: Please indicate any personal history below:

☐ ***Constitutional Symptoms***

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

☐ ***Eyes***

Eye disease or injury ..... No Yes
Wear glasses/contact lenses ..... No Yes
Blurred or double vision ..... No Yes

☐ ***Ears / Nose / Mouth / Throat***

Hearing loss or ringing ..... No Yes
Earache or drainage ..... No Yes
Chronic sinus problems or rhinitis ..... No Yes
Nose bleeds ..... No Yes
Mouth sores ..... No Yes
Bleeding gums ..... No Yes
Bad breath or bad taste ..... No Yes
Sore throat or voice change ..... No Yes
Swollen glands in neck ..... No Yes

☐ ***Cardiovascular***

Heart trouble ..... No Yes
Chest pain or angina pectoris ..... No Yes
Palpitation ..... No Yes
Shortness of breath w/walking
or lying flat ..... No Yes
Swelling of feet, ankles, or hands ..... No Yes

☐ ***Respiratory***

Chronic or frequent coughs ..... No Yes
Spitting up blood ..... No Yes
Shortness of breath ..... No Yes
Wheezing ..... No Yes

☐ ***Gastrointestinal***

Loss of appetite ..... No Yes
Change in bowel movements ..... No Yes
Nausea or vomiting ..... No Yes
Frequent diarrhea ..... No Yes
Painful bowel movements
or constipation ..... No Yes
Rectal bleeding or blood in stool ..... No Yes
Abdominal pain ..... No Yes

☐ ***Genitourinary***

Frequent urination ..... No Yes
Burning or painful urination ..... No Yes
Blood in urine ..... No Yes
Change in force of strain
when urinating ..... No Yes
Incontinence or dribbling ..... No Yes
Kidney stones ..... No Yes
Sexual difficulty ..... No Yes
Male - testicle pain ..... No Yes
Female - Pain with periods ..... No Yes
Female - Irregular periods ..... No Yes
Female - Vaginal discharge ..... No Yes
Female - Number of pregnancies ..... _____
Female - Number of miscarriages ..... _____
Female - Date of last pap smear ..... _____

☐ ***Musculoskeletal***

Joint pain ..... No Yes
Joint stiffness or swelling ..... No Yes
Weakness of muscles or joints ..... No Yes
Muscle pain or cramps ..... No Yes
Back pain ..... No Yes
Cold extremities ..... No Yes
Difficulty in walking ..... No Yes

☐ ***Integumentary (skin , breast)***

Rash or itching ..... No Yes
Change in skin color ..... No Yes
Change in hair or nails ..... No Yes
Varicose veins ..... No Yes
Breast pain ..... No Yes
Breast lump ..... No Yes
Breast discharge ..... No Yes

☐ ***Neurological***

Frequent or recurring headaches ..... No Yes
Light headed or dizzy ..... No Yes
Convulsions or seizures ..... No Yes
Numbness or tingling sensations ..... No Yes
Tremors ..... No Yes
Paralysis ..... No Yes
Head injury ..... No Yes

☐ ***Psychiatric***

Memory loss or confusion ..... No Yes
Nervousness ..... No Yes
Depression ..... No Yes
Insomnia ..... No Yes

☐ ***Endocrine***

Glandular or hormone problem ..... No Yes
Excessive thirst or urination ..... No Yes
Heat or cold intolerance ..... No Yes
Skin becoming dryer ..... No Yes
Change in hat or glove size ..... No Yes

☐ ***Hematologic / Lymphatic***

Slow to heal after cuts ..... No Yes
Bleeding or bruising tendency ..... No Yes
Anemia ..... No Yes
Phlebitis ..... No Yes
Past transfusion ..... No Yes
Enlarged glands ..... No Yes

☐ ***Allergic / Immunologic***

History of skin reaction of other adverse reaction to:
Penicillin or other antibiotic ..... No Yes
Morphine, Demerol
or other narcotics ..... No Yes
Novocaine or other anesthetics ..... No Yes
Aspirin or other pain remedies ..... No Yes
Tetanus antitoxin or other serums ..... No Yes
Iodine, Merthiolate, other antiseptic .... No Yes

Other drugs / medications _____
_____
_____
_____

Known food allergies _____
_____
_____
_____

Environmental allergies _____
_____
_____

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 office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services that I may need.

_____ _____
Signature of Patient, Parent, or Guardian Date

Doctor's Review

_____ _____
Signature of Doctor Date