

# Health History

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Date of last physical exam \_\_\_\_\_

Are you presently under a physician's care for any condition?  Yes  No

If yes, please state condition \_\_\_\_\_ Name of physician \_\_\_\_\_

What is the reason for today's visit? \_\_\_\_\_

**SYMPTOMS** Check (√) symptoms you currently have or have had.

<p><b>CONSTITUTIONAL</b></p> <input type="checkbox"/> Chills <input type="checkbox"/> Fever <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Sweats, especially at night	<p><b>CARDIOVASCULAR (cont'd)</b></p> <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	<p><b>RESPIRATORY</b></p> <input type="checkbox"/> Asthma <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Persistent cough
<p><b>EARS, NOSE, THROAT, MOUTH</b></p> <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Ringing in ears	<p><b>NEUROLOGICAL</b></p> <input type="checkbox"/> Dizziness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Numbness location _____ <input type="checkbox"/> Shaking	<p><b>MUSCLE/JOINT/BONE</b>        Pain, weakness, numbness in:</p> <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders <input type="checkbox"/> Fracture _____
<p><b>EYES</b></p> <input type="checkbox"/> Low vision <input type="checkbox"/> Double vision	<p><b>GENITO-URINARY</b></p> <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Urgency	<p><b>GASTROINTESTINAL</b></p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting
<p><b>SKIN</b></p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Sore won't heal	<p><b>GU: FEMALES</b></p> <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge Are you pregnant? <input type="checkbox"/> yes <input type="checkbox"/> no Number of children _____	<p><b>OTHER (Please list):</b></p> _____ _____ _____ _____ _____
<p><b>CARDIOVASCULAR</b></p> <input type="checkbox"/> Chest pain <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> High blood pressure	<p><b>ENDOCRINE</b></p> <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Heat intolerance	

**CONDITIONS** Check (√) conditions you currently have or have had.

<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Angina <input type="checkbox"/> Anorexia <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Blood clots <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts <input type="checkbox"/> Chemical dependency	<input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Headaches <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes <input type="checkbox"/> Hepatitis <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol	<input type="checkbox"/> HIV positive <input type="checkbox"/> Kidney disease <input type="checkbox"/> Liver disease <input type="checkbox"/> Migraines <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Pacemaker/AICD <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio <input type="checkbox"/> Prostatitis <input type="checkbox"/> Psychiatric care <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide attempt <input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcers <input type="checkbox"/> Urethral discomfort/infection <input type="checkbox"/> Other (list): _____ _____ _____ _____ _____
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**ALLERGIES or ADVERSE REACTIONS TO MEDICATIONS OR SUBSTANCES**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

