Health History **Page 1**

_____ _____ _____ **Date**_____/_____/_____

First Name **M.I.** **Last Name**

_____ _____ _____

Occupation **Date of Birth** **Primary Care Provider**

Reason for Visit:_____

Check if the patient has any problems with the following areas: **Are you Pregnant: _____**

GENERAL: □ fever □ chills □ night sweats □ fatigue □ chills □ weight loss □ weight gain □ daytime drowsiness

HEENT: □ vision changes □ hearing loss □ earache □ ears draining □ ears itching □ tinnitus □ nasal discharge □ nasal bleeding □ nasal obstruction □ Headaches □ sneezing □ congestion □ throat pain □ hoarseness □ sinus disease □ Dizziness

SKIN: □ rash □ skin cancer □ lesions □ pigmentary changes

CARDIOVASCULAR: □ shortness of breath □ with activity □ without activity □ chest pain

RESPIRATORY: □ wheezing □ asthma □ cough □ shortness of breath □ emphysema □ mucous

GI: □ nausea □ vomiting □ diarrhea □ constipation □ abdominal pain □ reflux

NEUROLOGICAL: □ numbness □ seizures □ loss of memory □ weakness

PSYCHIATRIC: □ depression □ anxiety □ bipolar disorder □ psychosis/hallucinations

ENDOCRINE: □ thyroid disease □ elevated calcium □ adrenal tumors

GENITO-URINARY: □ kidney stone □ prostate enlargement □ painful urination □ infections

HEMATOLOGIC/IMMUNOLOGIC: □ Immunodeficiency □ bleeding disorders □ history of blood transfusions

Please list all ALLERGIES to medications:
(or attach a list)

_____

_____

_____

_____

_____

Please list all REGULAR MEDICINES and doses:
(or attach a list)

_____

_____

_____

_____

_____

_____ _____ _____
First Name **M.I.** **Last Name**

MEDICAL HISTORY

Circle if the patient has or had the following: (put year diagnosed next to it)

Heart attack	_____	Cancer	_____
High blood pressure	_____	Pneumonia	_____
Diabetes	_____	Emphysema	_____
Mitral valve prolapse	_____	Bronchitis	_____
Stroke(s) / TIA's	_____	COPD	_____
TB	_____	AIDS	_____
Hepatitis	_____	HIV +	_____
Colitis	_____	Heart Conditions	_____

SURGICAL HISTORY

Circle if the patient has had any of the following operations: (enter the year the surgery was done in the space provided)

Hysterectomy	_____	Adenoidectomy	_____
Back or Disc operation	_____	Tonsillectomy	_____
Thyroid or Neck	_____	Breast Biopsy	_____
Appendectomy	_____	Hernia Repair	_____
Gall Bladder Removal (Cholecystectomy)	_____	Ear tubes - If so, number of times?	_____

List any **other operations** and year:_____
_____
_____

Has the patient had any **problems with anesthetics** used during surgery? YES NO
If yes, explain:_____

SOCIAL HABITS

Does anyone in the patient's house smoke? Yes No

Does the patient use tobacco? Yes No Type of tobacco used? Chew_____ Smoke_____Cigarettes_____ Cigars_____

How many cans, packs or cigars per day?_____ Is the patient tobacco dependent? Yes No
Quit?:_____ When?:_____

Does the patient drink alcohol? Yes No Type of alcohol used? Liquor____ Beer_____ Wine_____

How many drinks per week? _____ Is the patient alcohol dependent? Yes No

Has the patient had a blood transfusion? Yes No If so, what year?_____

Is the patient up to date on immunizations? Yes No Does the patient have any pets in the house? Yes No
If yes what type of pet? _____

FAMILY HISTORY

If family history is unknown please check here_____.

Circle the patient's **mother (M), father (F), brother (B), or sister(S)** if they have had any of the following illnesses or problems. If circled please indicate if they are still alive or deceased by marking A=Alive, D=Deceased next to the circled family member.

Heart Attacks	M	F	B	S	
Diabetes	M	F	B	S	
High Blood Pressure	M	F	B	S	
Tuberculosis	M	F	B	S	
Cancer	M	F	B	S	Type_____
Bleeding Disorder	M	F	B	S	