Health History

(Confidential)

Name: _____ Date of last physical examination: _____

SYMPTOMS: Check symptoms you currently have or have had in the PAST YEAR:

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Sweats
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Painful urination

MUSCLE / JOINT / BONE

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulder

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

SKIN

- ☐ Bruise easily
- ☐ Change in moles
- ☐ Rash / Itching
- ☐ Sore that won't heal

GASTROINTESTINAL

- ☐ Diarrhea
- ☐ Constipation
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Indigestion
- ☐ Vomiting

EYE, EAR, NOSE, THROAT

- ☐ Vision problems
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Sinus problems
- ☐ Sore throat
- ☐ Ringing in ears
- ☐ Earache

OTHER

- ☐ Other_____
- ☐ _____
- ☐ _____

CONDITIONS: Check conditions you have EVER HAD :

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ HIV positive
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ **Pacemaker**
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problems
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcer
- ☐ Vaginal Infections
- ☐ Venereal Disease

ALLERGIES: Please list any allergies to medication, foods, herbs or other factors: _____

_____

_____

(All information is strictly confidential.)

Family History	Diseases in the Family? (Arthritis, Strokes, Heart Disease, Cancer, Diabetes, TB. Kidney Disease, High Blood Pressure,Multiple Sclerosis)	Living or deceased?
Mother		L / D
Father		L / D
Brothers		L / D
Sisters		L / D
Grandmother(s)		L / D
Grandfather(s)		L / D

SERIOUS ILLNESS/INJURY & HOSPITALIZATIONS

Serious Illness/Injury/Hospitalizations Please include ANY Broken Bones, Surgeries, or Cancer	Year	Check if Hospitalized	Outcome

Have you ever had a blood transfusion? Yes___ No___ If Yes, please give approximate dates:

CURRENT MEDICATIONS	DOSAGE

OCCUPATIONAL CONCERNS: Check if you work exposes you to the following:

	Stress
	Heavy Lifting
	Hazardous Substances
	Hours on Computer

HEALTH HABITS

Substance	Amount Used Daily
Caffeine	____Cups/Day
Alcohol	____Drinks/Day
Tobacco	____#/Day/Week
Drugs	
Vape	

FOR WOMEN ONLY: PREGNACY HISTORY

Year of Birth	Sex of Child	Complications, if any
	M F	
	M F	
	M F	
	M F	
	M F	

I certify that the above information is complete and correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form:

Signature: **Date:**