

Health History

Patient Name: _____

Today's Date: _____

Date of Birth: _____

Age: _____

Date of last physical examination: _____

What is the reason for this visit? _____

Allergies: _____

List of current medications: _____

Pharmacy Name: _____

Phone: _____

Symptoms

Check symptoms you currently have or have had in the past year.

<u>General</u>	<u>Gastrointestinal</u>	<u>Eye, Ear, Nose, Throat</u>	<u>MEN only</u>
<input type="checkbox"/> Chills	<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Breast Lump
<input type="checkbox"/> Depression	<input type="checkbox"/> Bloating	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Erection difficulties
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Bowel changes	<input type="checkbox"/> Crossed eyes	<input type="checkbox"/> Lump in testicles
<input type="checkbox"/> Fainting	<input type="checkbox"/> Constipation	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Penis discharge
<input type="checkbox"/> Fever	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Double vision	<input type="checkbox"/> Sore on penis
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Earache	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Headache	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Ear discharge	
<input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> Gas	<input type="checkbox"/> Hay fever	
<input type="checkbox"/> Loss of Weight	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Hoarseness	
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Nosebleeds	
<input type="checkbox"/> Numbness	<input type="checkbox"/> Nausea	<input type="checkbox"/> Persistent cough	
<input type="checkbox"/> Sweats	<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Ringing in ears	
	<input type="checkbox"/> Stomach Pain	<input type="checkbox"/> Sinus problems	
	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Vision- Flashes	
	<input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Vision- Halos	
<u>Muscle/Joint/Bone</u>			
Pain, Weakness, or			
Numbness in:			
<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			
<u>Genito- Urinary</u>			
<input type="checkbox"/> Blood in urine			
<input type="checkbox"/> Frequent urination			
<input type="checkbox"/> Lack of bladder control			
<input type="checkbox"/> Painful urination			

<u>Cardiovascular</u>	<u>Skin</u>	
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Bruise easily	Last Menstrual Period: _____
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Hives	Date of Last PAP Smear: _____
<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Itching	Have you had a mammogram? _____
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Change in moles	Are you pregnant? _____
<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Rash	Number of Children: _____
<input type="checkbox"/> Rapid heart beat	<input type="checkbox"/> Scars	
<input type="checkbox"/> Swelling of ankles	<input type="checkbox"/> Sore that won't heal	
<input type="checkbox"/> Varicose Veins		

<u>WOMEN only</u>
<input type="checkbox"/> Abnormal Pap Smear
<input type="checkbox"/> Bleeding between periods
<input type="checkbox"/> Breast Lump
<input type="checkbox"/> Extreme menstrual pain
<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Nipple discharge
<input type="checkbox"/> Painful Intercourse
<input type="checkbox"/> Vaginal discharge
<input type="checkbox"/> Other: _____

Conditions

Check all conditions you currently have or have had in the past year.

<input type="checkbox"/> AIDS	<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Goiter	<input type="checkbox"/> Measles	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Migraine Headache	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Gout	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Cancer	<input type="checkbox"/> heart disease	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Hernia	<input type="checkbox"/> Mumps	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Herpes	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Emphysema	<input type="checkbox"/> HIV positive	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Polio	<input type="checkbox"/> Vaginal Infections
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Prostate Problem	<input type="checkbox"/> Venereal Disease