Health History
(Confidential)

Date: ____________________

Name: ______________________________________ Age: ______________ D.O.B: ________________

Marital Status: S ( ) M ( ) W ( ) D.( )   Date of last Physical Exam: ____________________

Symptoms: Check ( ) symptoms you currently have or had in the past year.

General		Gastro		Eye ,Ear, Nose, Throat		Men only	
Chills		Poor appetite		Bleeding gums		Breast lump	
Depression		Bloating		Blurred vision		Erection difficulties	
Dizziness		Bowel changes		Crossed eyes		Lump in testicles	
Fainting		Constipation		Difficulty swallowing		Penis discharge	
Fever		Diarrhea		Double vision		Sore on penis	
Forgetfulness		Excessive hunger		Earache		Other	
Headache		Excessive thirst		Ear discharge		**Women only**	
Loss of sleep		Gas		Hay fever		Abnormal pap	
Loss of weight		Hemorrhoid		Hoarseness		Bleeding between periods	
Nervousness		Indigestion		Loss of hearing		Breast lump	
Numbness		Nausea		Nosebleeds		Extreme menstrual pain	
Sweats		Rectal bleeding		Persistent cough		Hot flashes	
		Stomach pain		Ringing in ears		Nipple discharge	
		Vomiting		Sinus problems		Painful intercourse	
		Vomiting blood		Vision -flashes		Other	

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

				Date of last menstrual cycle
Arms		Hips		Date of last pap smear:
Legs		Neck		Have you ever had a mammogram?
Feet		Shoulders		Are you pregnant?
Hands		Back		Number of children:

GENITO-URINARY		CARDIOVASCULAR		SKIN	
Blood in urine		Chest pain		Bruise easily	
Frequent urination		High blood pressure		Hives	
Lack of bladder control		Irregular heartbeat		Itching	
Painful urination		Low blood pressure		Change in moles	
		Poor circulation		Rash	
		Rapid heartbeat		Scars	
		Swelling ankles		Sore that won't heal	
		Varicose veins			

CONDITIONS: Check ( ) conditions you have had in the past:

Aids		Chemical Dep.		High cholesterol		Prostate problem	
Alcoholism		Chicken Pox		HIV -Positive		Psychiatric care	
Anemia		Diabetes		Kidney Disease		Rheumatic fever	
Anorexia		Emphysema		Liver Disease		Scarlet fever	
Appendicitis		Epilepsy		Measles		Stroke	
Arthritis		Glaucoma		Migraine Headaches		Suicide attempt	
Asthma		Goiter		Miscarriage		Thyroid problem	
Bleeding disorder		Gonorrhea		Mononucleosis		Tonsillitis	
Breast Lump		Gout		Multiple sclerosis		Tuberculosis	
Bronchitis		Heart disease		Mumps		Typhoid fever	
Bulimia		Hepatitis		Pacemaker		Ulcers	
Cancer		Hernia		Pneumonia		Vaginal infections	
Cataracts		Herpes		Polio		Venereal disease	

MEDICATIONS: List the medications you are currently taking:	**Allergies To Medication:**

Family History Fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death	Check ( )if your blood relatives had the following:		
						Disease	Relationship to you
Father						Arthritis, Gout	
Mother						Asthma, Hay fever	
Brothers						Cancer	
						Chemical dependency	
						Diabetes	
Sisters						Heart Disease, Strokes	
						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

Hospitalization

Year	Hospital	Reason for hospitalization

(Women) (Men)

Pregnancy History / Number of children	Year	M/F	Complications if any

Have you ever had a blood transfusion? If so, give approx. date.____________

Serious Illness/Injury	Date	Outcome	Health Habits check ( ) which Substance you use and how much			Occupational Concerns	
			Caffeine			Stress	
			Tobacco			Hazardous substance	
			Drugs			Heavy lifting	
			Alcohol			Other	
			Other				

Your Occupation:

Pharmacy Name:________________________________ Phone Number:________________________________

Other medical history information that was not covered above, please fill in here:

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

Signature____ Date:______________________

Reviewed by____ Date:______________________